KORBIN COMMISSION FINAL REPORT.

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Foreword

On October 5, 2000, I was appointed to inquire and report on the contractual relationship between the provincial government and medical practitioners.

In this very short period of time, this Commission has learned of the longstanding and extremely complex relationships that exist between the provincial government and doctors. The incredibly valuable work our province's doctors perform in the face of changing demands on their profession and on our public health care system, makes it all the more important for us to find ways to make the system work. The Commission received many thoughtful submissions that assisted me in understanding the current difficulties and challenges that face the government, the health authorities, the BCMA and doctors in the delivery of health care in our province. I can say without a doubt that all those we heard from share a deep commitment to making our public health care system work.

Given the two months the Commission has had to fulfill its mandate, this report and its recommendations should be seen as a starting point. It is my sincere hope that, with the assistance of these recommendations, the provincial government and doctors will work to resolve their problems in a new spirit of trust and respect that is essential to successful bargaining relationships.

The work of this Commission could not have been possible without the efforts and expertise of a number of key individuals. I would like to take this opportunity to express my deepest thanks to Susan Arnold, Allan Black Q.C., Peter Gall, Sheila Moan, Helen Muir, Marli Rusen, Kristin Rasmussen, Marcia Smith and Laura Wanamaker for their assistance in the preparation of this report.

Judi Korbin
Commissioner

Introduction

On October 5, 2000, this Commission was established under the *Inquiry Act*, to inquire and report on the matters provided for in the following Terms of Reference:

1. To inquire into how the Provincial government and health authorities should enter into contractual relationships with medical practitioners to:

   (a) serve the public interest, and
   (b) provide certainty and continuity in the provision of patient care.

2. To recommend:

   (a) the elements that should be included in contracts to reflect the contractual relationships referred to in Section 1, and
   (b) changes, if any, to Acts or regulations needed to implement the recommendations made in response to Sections 1 and 2(a).

3. To submit to the Lieutenant Governor in Council an interim report by October 31, 2000, and a final report by December 15, 2000, concerning the foregoing.

The Interim Report raised for discussion a set of principles that would govern the creation of a more equitable and workable bargaining structure. In particular, the contractual relationships between the government and doctors must:

- allow doctors to protect their negotiated remuneration;
- acknowledge the government's need to control the cost of doctors' services;
- ensure that the bargaining structure works properly and fairly for the setting of doctors' remuneration;
- ensure that the various agencies, authorities, and persons representing the government are effectively coordinated in bargaining with doctors;
- ensure that the bargaining structure provides a mechanism to deal efficiently with legitimate emergent and/or critical issues; and

- protect the public interest in achieving a continuous and reliable supply of doctors' services, without resorting to collective withdrawals of service as a bargaining tactic.

This report examines the past and present bargaining structure between the government and the British Columbia Medical Association (the "BCMA"). It also reviews the relationship between regional health authorities and doctors, recent withdrawals of doctors' services, alternative methods of payment, and bargaining structures in other provinces and territories. This report also presents an overview of submissions made to the Commission.

Finally, the report considers the underlying problems of the contractual relationships that have led to withdrawals of service, and makes recommendations that address these problems as well as provides for mechanisms to aid in their implementation. A summary of these recommendations may be found at Appendix A.

The Commission's Interim Report was available to the public for comment and feedback for consideration in the drafting of this report. To stimulate public discussion, the Commission ran advertisements in print media and posted a website on the Internet. In response, the Commission received over 50 submissions. In the course of its work, the Commission has had the opportunity to consult with a variety of interested parties and individuals. A list of persons from whom the Commission has received submissions may be found in Appendix B.

Origins of the Public Health System

Prepaid medical coverage was introduced in British Columbia in the 1940s. Private sector medical insurance plans were developed by the medical profession itself, the Medical Services Association (the "MSA"), and by both employer and employee organizations, such as West Kootenay Power and Light Company, the teachers' provincial organization and the employees' organization of Cunningham — Western Drugs. These plans were, for the most part, not-for-profit plans, although there were a few commercial-for-profit insurance carriers.[1]

Private prepaid medical plans continued to proliferate during the 1950s and 1960s. In 1954, British Columbia Medical Services Incorporated was established to provide coverage for that sector of the province's population, i.e. individuals and small groups, that was ineligible for coverage under the MSA or other private employer plans.[2]

Under these private sector prepaid medical plans the carrier determined which medical services it would cover, and set the schedule for payment to the doctors. Payment was made on a fee-for-service basis and the fee payable was typically based on a percentage of the fee established under the BCMA fee schedule. Under these plans, doctors had the ability to extra-bill, that is, bill the patient an additional amount for the service rendered over and above that paid by the plan, but for the most part doctors did not do so.

Persons in the group were charged premiums that could fluctuate based on the "experience rating" of the group. That is, if a particular group utilized the plan in excess of the actuarial norm, the premiums for that group would increase. Conversely, groups which had lower utilization than the norm would be assessed lower premiums. Thus, there was a direct correlation between utilization and the cost of the coverage.

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[1] M.G. Taylor, *Insuring National Care: The Canadian Experience* (London: The University of North Carolina Press, 1990); C.D. Naylor, *Private Practice, Public Payment Canadian Medicine and the Policies of Health Insurance 1911-1966* (Montreal: McGill-Queen's University Press, 1986); C.H. Shillington, *The Road to Medicare in Canada* (Toronto: Del Graphics Publishing Dept., 1972).

[2] Shillington, *Ibid*, pp. 56-57, 109-110; C.E. McDonnell, "The Ghosts of Contract Medicine" (1998) 40(8) *BCMJ* 346; C.E. McDonnell, "Medical Practice in the 20th Century in the Lower Mainland" (2000) 42(4) *BCMJ* 214.

In 1955, the *Public Services Medical Plan Act* was passed, which provided employees of the government, government corporations, boards and authorities, and pensioners receiving a pension under the *Civil Service Superannuation Act,* with a prepaid medical insurance plan. The premium cost was split between the government and the particular employee or pensioner — and again payment to physicians under this plan was on a fee-for-service basis.

Except with respect to these employees and pensioners, the government did not become involved in the provision of prepaid medical insurance plans until the 1960s.

In 1964, the Royal Commission on Health Services Report (the "Hall Commission Report") was issued. It recommended universal comprehensive medical care coverage be made available to all residents of Canada, regardless of ability to pay. The report resulted in a flurry of activity regarding provision of medical coverage for Canadian residents.

In 1965, the BC Medical Plan ("BCMP") was established. The plan provided prepaid medical insurance to individuals regardless of age or physical condition. It also provided for payment of physicians on a fee-for-service basis. Premium costs were subsidized for individuals with marginal incomes. The existing private sector plans continued to operate, and at that time there was no intention to preclude their continued operation.

Also, in response to the Hall Commission Report, the federal government passed the *Medical Care Act*, 1966. That *Act* established a federal/provincial cost sharing arrangement whereby the federal government agreed to pay 50 percent of the cost of insured doctors' services rendered in those provinces that had medical insurance plans which met the criteria set out in the *Act*. Those criteria were: the plans had to be universal, comprehensive, portable, and operated and administered by a public non-profit authority appointed or designated by the provincial government.

The *Medical Care Act* did not specifically prohibit extra-billing. It required that any provincial insurance plan that was eligible for the federal cost contribution must provide for:

> ...the furnishing of insured services upon uniform terms and conditions to all insurable residents of the province...on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons.
> (Section 4 (1)(b))

Flowing from the passage of the federal *Medical Care Act*, the provincial government passed the *Medical Services Act*, RSBC 1967, c.24, which created the Medical Services Commission (the "MSC").

The MSC was the public non-profit authority required by the federal *Medical Care Act*. It was responsible for the administration and operation of the voluntary medical insurance plan in the province. Under the regulations to this *Act*, the Medical Services Plan of British Columbia was established as the overall medical care insurance plan (the "Plan"). This was the introduction of what we now know as government "medicare". BCMP and two additional prepaid medical insurance carriers, CU&C Health Services Society (CU&C) and MSA, were licensed to operate as carriers for the Plan. These were the only three licensed carriers in the province.

Under the *Medical Services Act*, the MSC was responsible for approving the contracts entered into by the carriers for the provision of insured services, fixing the premium cost for coverage and prescribing both the medical services to be covered under the Plan and the fee schedule for those services. Under this system, the tariff of fees was established by the BCMA and approved by the Commission. Physicians were paid under the Plan on a fee-for-service basis, and the "experience rating" concept for the determination of premium cost for the particular group was ended.

The MSC was also charged with the responsibility of establishing the budget for the provision of doctors' services in the province, and for overseeing the assessment and approval of individual accounts rendered by doctors for insured services.

Under the regulations to the *Act*, physicians had the ability to opt out of the Plan, and extra-bill patients for insured services, as long as three conditions were met. Those conditions were as follows: the patient was made aware that he/she would be extra-billed in advance of the provision of the service; consented to that extra charge; and, that the MSC was advised of the amount of the extra charge (Section 5 of the Regulation, and in particular, Section 5.11). A physician's ability to extra-bill was arguably restricted in 1974 by an amendment to Section 5.11 of this regulation which suggested that, without an agreement between the MSC and the doctor, doctors could only extra-bill if the patient requested unusual time consuming service over and above what was ordinarily required, and the patient agreed to the extra-billing before the service was performed (B.C. Reg. 213/74).

In 1975, the province stopped using licensed carriers to provide basic medical insurance to residents, and the Medical Services Plan ("MSP") became the sole carrier. Thus, the MSC became the sole administrator. The MSC, by regulation, was granted additional powers to not only approve, but also to prescribe a tariff of fees for the payment of insured services. As a matter of practice, the BCMA continued to set its tariff of fees. This tariff was reviewed by the MSC, which then set the fee schedule for MSP, based in whole or in part on the BCMA tariff.

In 1984, the *Canada Health Act* was passed, replacing the *Medical Care Act*. The new *Act* set five criteria which had to be met by the provincial health insurance plans before they would qualify for federal funding: public administration; portability; universality; comprehensiveness; and, accessibility. In order to ensure accessibility, the *Act* explicitly required the provinces to prohibit user charges and extra-billing (Sections 18 and 19). If a province permitted either user charges or extra-billing, it would not qualify for the full cash contribution under the *Act* from the federal government for the fiscal year in which the province allowed the practice. Thus, the practice of allowing extra-billing and user charges was eliminated in British Columbia.

Since 1984, the MSC has continued to administer MSP in British Columbia. The BCMA continues to set its fee tariff, which is the basis for the MSC approved fee schedule under MSP.

Statutory Framework

The present statutory framework in British Columbia for the administration of the Medical Services Plan is contained in the *Medicare Protection Act*, RSBC 1996, c. 286.[3]

The *Medicare Protection Act* continues the MSC as a tri-partite body made up of nine members. Three members of the MSC are nominated by the BCMA, three are appointed to represent the government, and three are appointed on the joint recommendation of the Minister of Health (the "Minister") and the BCMA to represent beneficiaries.

The function of the MSC is described in Section 3(3) of the *Act* as follows:

> …to facilitate, in the manner provided for in this Act, reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan.

Under Section 25 of the *Medicare Protection Act*, the MSC is given the power to determine the amount of funds available for doctors' fees-for-service. That amount is called the available amount. Section 25(1) reads as follows:

> Available Amount
> 25(1) The commission may set the available amount for a category that may be paid under all payment schedules to practitioners in the category for rendering benefits under this Act in the fiscal year specified by the commission.
>
> (2) The total amount that may be paid by the commission to all practitioners in a category for rendering benefits under this Act in a fiscal year must not be greater than the available amount for the fiscal year.

[3] This is successor legislation to the *Medical Services Act*, RSBC 1967, c.24 and the *Medical and Health Care Services Act*, *SBC 1992, c. 76.*

Section 24 of the *Medicare Protection Act* requires that all payments of benefit plans and doctors' fee-for-service claims in a given year are limited to the amount set by the Legislature for that purpose. Section 24(1) and (2) provide:

> 24(1) All reasonable and practical measures must be taken by the commission to ensure that the total of payments made under Sections 26 and 27 for a fiscal year is not greater than the appropriations for the fiscal year for those payments and these measures may include the establishment of public or professional educational programs, the establishment or limitation of benefits, the establishment of guidelines for the rendering of benefits or the making of adjustments under subsection (2).
>
> (2) If the commission considers that payment for a fiscal year under all payment schedules to practitioners in a category will be greater than or less than the available amount for that category, the commission may adjust its payments to the practitioners in the category under the payment schedules to a level that the commission considers appropriate to remain within the available amount for the fiscal year.

Under Section 5 of the *Medicare Protection Act*, the *Financial Administration Act*, RSBC 1996, c. 138 applies to the MSC as though the MSC were a division of the Ministry administered by the Minister.

The process by which the available amount is set begins with the MSC making a budget request to the Minister who, in turn, makes a request to Treasury Board. The amount approved by Treasury Board is the amount allocated to the MSC for the purpose of setting the available amount in any given fiscal year.

The Evolution of Fee Negotiations in Canada

In the early days of medicare, provincial governments and medical associations utilized informal processes in their negotiations over the content of the physician fee schedule and the size of total fee increases.[4] Within each medical association, doctors negotiated the allocation of fee increases across medical fee items defined by specialty.[5]

Also at this time, government attempts to contain the total cost of doctors' services (physician expenditures) focused on limiting the growth of physician fees. However, ten years later, by the late 1970s, federal funding had eroded and provinces faced with fiscal restraint took notice that physician expenditures represented one of their largest unpredictable budget items. Thus, the management of physician expenditures came to the forefront of negotiations and changed the nature of the relationship between the parties.[6]

The provinces handled this change in two distinct ways. Quebec, Ontario, Manitoba, Alberta, and British Columbia developed a more formalized approach to negotiations based on their perceived need to move to negotiations with defined structures, roles and processes to accommodate the increasingly complex issues facing medical associations and governments. Structures such as master agreements and dispute resolution mechanisms were put in place to deal with the competing interests of the parties. Unfortunately, the competing interests of the parties resulted in adversarial relations and at times public confrontation.[7]

In Saskatchewan and the Maritime Provinces, the parties engaged in more informal consultative processes that reflected a greater degree of mutual accommodation. In the Maritime Provinces at least, this was in part due to the smaller community of physicians and the familiarity of the parties.[8]

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[4] Lomas J, Charles C, Greb J, " The Price of Peace: The Structure and Process of Physician Fee Negotiations in Canada", McMaster University Centre for Health Economics and Policy Analysis Working Paper #92-17, August 1992.
[5] Katz, S., Charles, C., Lomas, J., Welch, H.G., 1997. Physician Relations in Canada: Shooting Inward as the Circle Closes. *Journal of Health Politics, Policy and Law* 22(6)1413-1431.
[6] *Supra*, note 4.
[7] *Ibid.* at 169.
[8] *Ibid.* at 169.

In 1976, Quebec separated from the adversarial group and established its own unique negotiating structure. Quebec's approach incorporated a comprehensive view of the issues at stake. As a result, it adopted complex bargaining structures and technical payment rules, including individual income thresholds for general practitioners and global physician expenditure targets.

Most importantly for future relations, Quebec isolated fee negotiations from external conflicts between the parties over medical care issues. This was achieved by having clear definitions of what issues had standing at the bargaining table.[9]

Meanwhile, other provinces from the adversarial group proceeded along a more traditional bargaining track characterized by an action-reaction cycle of negotiations. As well, adversarial relations between the parties resulted in governments having a greater propensity to legislate rather than negotiate solutions to issues of cost containment. For instance, in the early 1980s in British Columbia, a solution to physician supply and distribution concerns was sought through legislation to control access to provincial health insurance plan billing numbers.[10]

In the 1990s, the recession hit and eroded the capacity of the public sector to provide previous levels of funding for health care. Thus, the focus of fee negotiations moved from simply containing fee prices to containing income potential through restrictions on both prices and quantity of services provided and, finally, to limiting total physician expenditures.[11] Hence, beginning in late 1991, provincial governments in Ontario, Alberta and British Columbia capped the growth of physician expenditures. Aggravating the situation was the fact that the federal government commenced reductions in health care transfer payments to the provinces in 1996.

Under a global hard cap, there is no sharing of cost overruns. If expenditures exceed the cap, they are entirely recouped from physicians in a number of ways including proration.

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[9] *Ibid.*
[10] *Ibid.* at 171.
[11] *Ibid.* at 178.

Proration means a temporary reduction in the payment for services through an across-the-board percentage reduction in fees. In contrast, a soft global cap refers to arrangements where expenditure targets are set and if exceeded, the province and the medical profession share the cost of the overruns.[12]

Following the earlier response by Quebec, all provinces began adopting more formalized negotiation structures that reflected a mutual accommodation style of bargaining. Faced with the need to address more complex issues such as global expenditure caps, accountability for utilization increases, physician supply and distribution, and alternative payments modes, structures were put in place to encourage ongoing consultation between the parties.

One structure that was introduced in almost all of the provinces was the Joint Management Committee (the "JMC") made up of physicians and government representatives.

These committees are intended to be the vehicles through which details of expenditure caps are negotiated and implemented.[13] The idea of such a committee assumes that both parties have rights in the determination of matters related to physician remuneration. Although JMCs brought medical associations to an expanding negotiating table, the committees also represented a visible threat to the solidarity of association members. Some viewed membership on these committees as "sleeping with the enemy."[14]

Under global expenditure caps, medical associations like the BCMA have been faced with growing inter-specialty conflicts over the internal allocation of available funds. The debate over how to allocate limited resources has increased division between general practitioners and specialists and created new divisions between younger and older physicians, rural and urban physicians, academic and non-academic physicians and physicians in different provinces. Medical associations have sought ways to

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[12] Barer, M.L., Lomas, J., Sanmartin, C. 1996. Re-minding our Ps and Qs: Medical Cost Controls in Canada. *Health Affairs* 15(2): 216-234.
[13] *Ibid.* at 226.
[14] *Supra*, note 4 at 1419.

minimize the friction between these groups. For instance, they avoided adopting policies to limit utilization that could unfairly penalize specific specialty groups.

Where proration was applied to meet expenditure caps, attempts were made to distribute the burden somewhat evenly across physician members. As well, they increasingly introduced formal internal bargaining processes, such as binding arbitration, to make the rules of the debate about income limits more explicit.[15]

Global expenditure caps also create conflict between physicians' individual economic self-interest and their collective interest in constraining total billings within the capped budget. It intensifies the need for collective cooperative approaches to managing utilization and heightens each physician's incentive not to cooperate: a physician gains the most by not restraining billings while all others do; he or she loses the most by restraining billings while all others do not. If a physician does not have some assurance that most physicians will act cooperatively, it is in his or her interest to "defect." Defection by several physicians leads to physicians all being worse off, as billings exceed the cap and proration is required.[16]

Recognizing that strategies to meet expenditure caps would alienate some physicians, the Ontario Medical Association (the "OMA") sought and received from the provincial government through legislation greater formal authority over their members. In 1991, the OMA was granted exclusive bargaining rights for nearly all physicians, and won a mandate that required all physicians in the province to pay annual dues to the association regardless of membership status (Rand agreement).

In 1996, a new Ontario provincial government, in response to more than $300 million in overruns and inter-specialty fee inequities, posed new legislation that would disband the JMC, remove sole negotiating rights from the OMA, and would even place the power to adjust individual fee differentials back into the hands of the Ministry of Health. Reeling from the extent of this legislation, the OMA stopped enforcing the Rand agreement for a number of months and reverted to only collecting

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[15] *Ibid.* at 1422.

[16] Hurley, J., Card, R. 1996. "Global Physician Budgets as Common-Property Resources: Some Implications for Physicians and Medical Associations." *CMAJ* 154(8) 1161.

voluntary dues payments.[17] Currently, physicians who practice on a fee-for-service basis and do not voluntarily pay OMA dues will have the amount recovered from their MSP payments by the provincial government pursuant to the 1991 legislation. Overall, global expenditure caps have weakened the relationship between doctors and the government and created issues for the profession that are internally divisive. As a result, there is a view held by some that new organizational structures, decision-making processes and attitudes about the management of physician expenditures are required to mend the problems caused by global expenditure caps.[18]

[17] *Supra*, note 4 at 1423.
[18] *Supra*, note 13 at 1166.

Parties Involved in Fee Negotiations in British Columbia

The British Columbia Medical Association

Founded in 1900, the BCMA is a voluntary association of British Columbia's medical doctors, including post-graduate trainees and students enrolled in the Faculty of Medicine at the University of British Columbia ("UBC"). Originally formed by physicians from a variety of small local medical societies who wished to create a single body to lobby the province respecting medical issues, including legislation. The BCMA is now a society that represents approximately 7,000 members.

The objective of the BCMA, in a broad sense, is to advance the practice and science of medicine and the health of British Columbians by working for the improvement of medical education, health care legislation, and hospital and other health services.

An equally important objective of the BCMA is to advance the economic welfare of its members. The BCMA's collective bargaining role emerged in the 1960s with the introduction of medicare. By agreement with the government and the MSC, the BCMA is granted the sole and exclusive right to represent physicians who practice medicine on a fee-for-service or a sessional basis and who participate in the MSP.

BCMA Board of Directors/Executive

The Board of Directors of the BCMA is comprised of 30 district delegates representing 16 geographic districts, three Canadian Medical Association directors, one representative from each of the Society of General Practitioners and the Society of Specialist Physicians and Surgeons, and five elected officers. In addition, the following non-voting members sit on the board: the Chairs of the Council on Health Promotion, the Council on Health Economics and Policy and the Council on Public Affairs and Communications; the President of the BCMA Auxiliary; and representatives of the Medical Undergraduate Society, the Professional Association of Residents, and the UBC Faculty of Medicine. The three BCMA appointees to the MSC are invited to the Board meetings as observers.

Out of the 30 district delegates, traditionally 18 have been elected from in and around Vancouver and Victoria.

The eight member Executive Committee consists of the five elected officers, the Board Chair, and two Board members appointed by the Board. The Executive's mandate is to carry out the operational aspects of policies set by the Board and to act on behalf of the Board between Board meetings.

The Negotiating Structure of the BCMA

The BCMA Negotiations Department represents members in contract negotiations with the government and other agencies. The Department is composed of the Director of Negotiations, three lawyers, one researcher and support staff. The Negotiations Department conducts negotiations with the government respecting fees and the effect of budget shortfalls. The Department also organizes and leads negotiations and administers contracts once they are negotiated.

A negotiating committee comprised of one representative from the Society of General Practitioners, one representative from the Society of Specialists, one general practitioner and one specialist representing the Board, and the Director of Negotiations drafts the proposed agreements between doctors and the government. To ensure members have an opportunity to contribute, the Committee seeks input from the BCMA membership, the Society of General Practitioners and the Society of Specialists. Once the proposed agreement has been drafted, it is presented to the Negotiations Advisory Group for recommendations and subsequently to the Board of the BCMA, who can adopt, reject or send back the agreement. Once the Board has accepted an agreement, it must be ratified by the BCMA membership. This group has the authority to decide issues such as negotiating strategy and core objectives and does not require further input from the Board.

A majority of the members of the BCMA is required for approval of any of the proposed agreements between the BCMA and the government, the MSC or any paying agency relating to compensation for medical services.

The Provincial Government

The Ministry of Health is responsible for bargaining with doctors over compensation for medical services. The Master Bargaining Committee conducts all negotiations with the BCMA. This Committee is currently comprised of the Deputy Minister of Health ("DM"), the Assistant Deputy Minister of Health ("ADM"), the Deputy Commissioner of the Public Service Employee Relations Commission ("PSERC"), and an external member.

Since 1991, there has been a series of seven Ministers of Health and six DMs overseeing the government's negotiations with the BCMA. The same external member has sat as the Committee's spokesperson since 1992.

Recently, a new ADM position within the Ministry has been created to oversee the Labour Relations and Negotiation Support Branch. Under the direction of the new ADM, the branch will guide and coordinate negotiations with physicians.

In February 2000, the government and the BCMA agreed to a new conceptual framework for the negotiation of their agreements. The illustration below shows the new structure for agreements between the government and the BCMA (Figure 1).

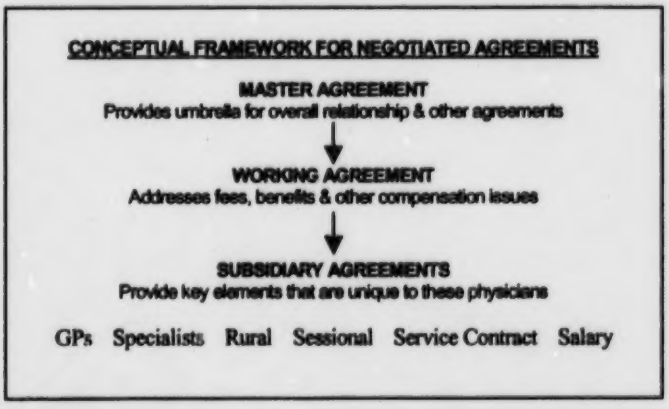
CONCEPTUAL FRAMEWORK FOR NEGOTIATED AGREEMENTS
MASTER AGREEMENT
Provides umbrella for overall relationship & other agreements
WORKING AGREEMENT
Addresses fees, benefits & other compensation issues
SUBSIDIARY AGREEMENTS
Provide key elements that are unique to these physicians
GPs Specialists Rural Sessional Service Contract Salary

Figure 1

Pursuant to this new structure, separate bargaining tables will exist for each of the subsidiary agreements. The government will have a negotiating team at each table

and an advisory caucus, although not present at the table, available to assist the team. These negotiating teams will be comprised of individuals who are familiar with the issues unique to the particular subsidiary agreement. For example, the Rural Agreement negotiating team will have representatives from Regional Operations and other labour relations support persons from the Ministry. An advisory caucus of CEO's of regional health authorities will be available to assist the team during negotiations. The Service Contract negotiating team will be comprised of senior Ministry staff, including personnel from the Alternative Payments Branch (the "APB"), the Executive Director of Acute and Tertiary Care and legal counsel.

The Master Bargaining Committee will continue to negotiate the Working Agreement as well as agreements for general practitioners and specialists. In addition, where a dispute arises at a subsidiary table, the Committee will attempt to resolve it at the main Working Agreement table.

Overseeing each of these negotiations is the Negotiation Coordinating Committee. This committee consists of the ADM with the chief spokesperson for each subsidiary agreement negotiating team. The ADM on behalf of the Committee will continue to seek a mandate to bargain with the BCMA and refer any proposed agreement to the Cabinet or Treasury Board for ratification.

The Negotiation Coordinating Committee has been created to coordinate the issues to be raised at each of the negotiations. It will ensure that issues are identified and then determine how they are to be resolved. Before any one subsidiary agreement can be finalized, all negotiations over the subsidiary agreements and the Working Agreement must be concluded. The Committee will ensure that each of the agreements is integrated so that the government can determine the projected overall cost of the agreements.

The Medical Services Commission

The MSC was created in 1967 under the *Medical Services Act*. Originally, the MSC was comprised of three government appointees. In 1975, the *Medical Services Act*

was amended so that the MSC had one member. From 1980 to 1992, the Ministry appointed the chair of the MSC.

In 1992, the *Medical Services Act* was replaced by the *Medical and Health Care Services Act* and, following a bitter dispute between the government and the BCMA in negotiations of their agreements, the MSC in its current structure was established. This structure was continued under the *Medicare Protection Act.*

In response to concerns about the structure and operation of the MSC, C. Lynn Smith, Q.C., conducted a review of the MSC in 1998. In her review, Smith found that the BCMA and the government held different views on the independence of the MSC. The BCMA's view is that with respect to its administrative and policy duties, the MSC was intended to be independent of the government. On the other hand, the government's position is that the Legislature intended the MSC to be closely controlled by and part of the Ministry. Its view is that the MSC does not have an independent policy setting function.

Smith recommended clarification of the MSC's role in recommending the available amount. In particular, she noted that the criteria to be applied by the MSC in formulating its recommendations should be clarified.

While Smith proposed new models for the MSC, she did not make a recommendation as to which one was the best. Rather, she encouraged the parties to agree upon one.

History of Agreements between the BCMA and the Government

Since the mid-1980s, the government and the BCMA have entered into a series of agreements outlining the terms and conditions under which doctors provide medical services to British Columbia residents. Until 1989, a form of master agreement, containing provisions establishing physicians' fees-for-services governed the relationship between the government and the BCMA. This agreement, however, contained no provisions regarding the establishment of a global budget for the payment of these fees, and contained no provisions which would allow the government to address circumstances in which fee-for-service payments were projected to, or did, exceed the amounts budgeted for these services. Accordingly, during this time period there was no hard cap on the amount of money that the government could be required to expend for physician services.

In 1989, the BCMA and the MSC entered into negotiations through a number of committees resulting in an agreement respecting the funding of fee-for-service physician payments in the 1990/91 and 1991/92 fiscal years. In addition to establishing the rates to be paid for doctors' services, the 1989 agreement also contained provisions designed to limit government expenditures on fee-for-service payments by slowing the rate of growth of demand for physician services. Specific targets were agreed to by the parties in this regard. The parties also agreed that part of the responsibility for the control of utilization growth would be borne by the profession itself.

At the end of the 1991/92 fiscal year, the aforementioned utilization control measures had not succeeded and expenditure goals were not met.

In 1991, a new government took office. The government was unhappy with the existing agreements with the BCMA and introduced Bill 71, the *Medical and Health Care Services Act* (now the *Medicare Protection Act*).

As well, the government passed legislation extinguishing an agreement reached between the previous government and the BCMA in 1990 that created a pension

arrangement for physicians. This matter became part of a dispute that lasted until December 1993. In the end, the government agreed to reinstate the plan, with only minor modifications. There was no retroactivity and only one-half of the annual allocation was available for the 1992/1993 fiscal year. The government explains that in lieu, the value of the plan was added to the available amount in the 1991/92 fiscal year. The Contributory Professional Retirement Savings Plan provides that the government will match doctors' contributions to the plan up to a set amount based on the global allocated amount of $25 million.

The Master Agreement

Following prolonged negotiations, the government and the BCMA in December 1993 reached a new Master Agreement. It provides for the involvement of the BCMA in a broad range of issues relating to the administration of the MSP, and sets out specific provisions requiring the government to consult with the BCMA regarding the establishment of the available amount of budget funding for physician services. The Master Agreement contains extensive provisions regarding the establishment of doctors' fees, and the provision of benefit plans. It outlines the process that is to be followed by the MSC in prorationing doctors' fees. Proration is defined in Article 1(u) as "a temporary reduction in the payment for a service or services below the fees listed in the Payment Schedule." The Master Agreement also contains provisions to continue the Northern Isolation Allowance program (the "NIA"), designed to develop and maintain incentives for practice in northern isolated communities.

Article 9 of the Master Agreement provides a process for the negotiation, mediation, and ultimately the arbitration of "working agreements" between the parties. Working agreements contain provisions concerning such matters as overall (gross) fee changes to the fee-for-service payment schedule, sessional payment rates and other benefits and programs. At the same time the Master Agreement was concluded, the parties also agreed to a Working Agreement covering the period from April 1, 1992 to March 31, 1997.

The 1993 Working Agreement

The 1993 Working Agreement established the available amount for the fiscal years 1992/93 to 1996/97. It also established the fees that were to be paid to fee-for-service physicians over the term of the agreement. In addition, the agreement contained provisions imposing specific responsibilities and obligations on the parties regarding utilization growth. In the 1993 Working Agreement, the parties accepted responsibility and obligations amounting to a cumulative reduction in utilization of some $383.2 million over the term of the agreement.

Article 6.3 of the agreement set out the specific responsibilities of the BCMA regarding utilization reductions. The consequences of any failure by the BCMA to meet utilization reduction targets were specified in Article 6.4.

In essence, it provided that should the BCMA fail to carry out its obligation as outlined in the agreement such that total physician expenditures exceeded the available amount, any excess costs would be the BCMA's responsibility. The MSC had the authority to determine the mechanism, which included proration, to recover the shortfall.

Under the 1993 Working Agreement, the government also assumed responsibility for reductions in MSC Total Claims Costs, amounting to some $90 million over the term of the agreement. The consequences of a failure on the part of the government to meet its responsibilities in this area were specified in Article 6.7, which required the government to add to the available amount the amount by which it failed to meet its utilization reduction commitments.

The Renewed Working Agreement

The utilization control targets outlined in the 1993 Working Agreement were not met. In light of the parties' failure and the severe fiscal constraints which were faced by the government at that time, the government approached the BCMA seeking to renegotiate the Working Agreement. Subsequent negotiations resulted in a Renewed Working Agreement, whose term covered the last year of the 1993 Working

Agreement and continued until the end of the 1997/98 fiscal year. Therefore, the Renewed Working Agreement set out the available budget for the fiscal years 1995/96, 1996/97 and 1997/98. The available amount for 1995/96 was determined as the actual amount of all expenditures in that fiscal year. As part of the Renewed Working Agreement, the government agreed, in effect, to absorb in the 1995/96 fiscal year the full cumulative impact of the parties' failures to reduce utilization levels in accordance with the 1993 Working Agreement. This amounted to approximately $75 million.

The parties also agreed to increase physician fees by two percent, to the extent that the increase could be funded within the amounts provided for in the Renewed Working Agreement, which set the available amounts for the fiscal years 1995/96, 1996/97 and 1997/98.

The Renewed Working Agreement also represented a significant move away from the model of shared responsibility in the 1993 Working Agreement. Under the Renewed Working Agreement, the BCMA agreed to assume full responsibility for controlling utilization rates in order to ensure that the two percent fee increase could be funded within the available amounts.

During the course of the 1997/98 fiscal year, it became clear that the BCMA's utilization control measures would not be successful in restraining expenditures within the agreed upon available amount. As a result, a proration rate (i.e. reduction) of 4.4 percent was applied to all fee-for-service claims beginning in August 1997.

And again, in the 1998/99 fiscal year, it became necessary for the MSC to prorate fee-for-service claims. A proration rate of 4.4 percent was applied to claims with a date of service between April 1 and November 30, 1998, and a rate of 3.3 percent was applied to claims between December 1, 1998 and January 31, 1999. No proration was applied to claims between February 1 and March 31, 1999.

Although $52 million was collected through proration in 1998/99, final reconciliation indicated that only an amount of $28.8 million had been required for claims to remain within the available amount. Therefore, in January 2000 the balance

(approximately $23 million) was returned to BCMA practitioners who had been prorated for services rendered between April 1, 1998 and January 31, 1999.

In response to proration, the BCMA unilaterally introduced a policy of "rationed access days" ("RADs"). Doctors were instructed not to schedule or to provide patients with elective office visits or elective procedures (diagnostic or therapeutic) on these days. In March of the 1997/98 fiscal year, RADs were announced for three regular weekdays. In the following fiscal year, there were 20 additional RADs. No RADs were scheduled or implemented in the 1999/00 fiscal year.

A recent study by Hanvelt, R. et al. considered the effects of RADs on physician fee-for-service payments.[19] The study found that services provided to British Columbia residents on the 1998/99 RADs were significantly curtailed. On RADs, doctors' billing patterns were similar to statutory holidays or weekend days. Nonetheless, the study also concluded that many of the services that would have been provided on RADs were merely rescheduled to other days. Thus, only an estimated $22.4 million in services were not provided in the 1998/99 fiscal year due to RADs. The expenditures for services that were likely rescheduled to non-RADs is an estimated $39.5 million.

In the spring of 1997, the parties began negotiations toward a new agreement in respect of the 1998/99 fiscal year. For the first time, the parties were not successful in obtaining an agreement. As a result, it was necessary for the parties, as contemplated by Article 8 of the Master Agreement, to appear before the MSC to make recommendations regarding the amount that the MSC should request from the government in respect of 1998/99 fiscal year.

The amount requested by the MSC was some $80 million less than the amount suggested by the BCMA. As a result, the BCMA commenced arbitration proceedings challenging the MSC's recommendation. The parties also became involved in a number of other disputes under the dispute resolution provisions of the Master Agreement.

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[19] Hanvelt, R.A. et al., *The Effects of Rationed Access Days (RADs) on Physician Fee-for-service Payments in B.C.*, March 2000 Health Human Resources Unit: Research Report.

Notwithstanding these difficulties, the parties did begin to meet to seek some resolution to these outstanding issues and to find a new framework for the relationship between them, which would satisfy the mutual interests of the government and doctors. These negotiations eventually resulted, in February 2000, in the "Framework Memorandum".

The Framework Memorandum

The stated purpose of the Framework Memorandum is to resolve outstanding issues and to enable the parties to enter into agreements that will ensure the availability and provision of physician services during the terms of the resulting agreements.

The Framework Memorandum extends the life of the Master Agreement until March 31, 2001, and provides another two percent fee increase for physicians effective September 1, 2000. The Memorandum also contains provisions establishing the available amount for 1999/00 and 2000/01.

Like the 1993 Working Agreement and its predecessors, the Framework Memorandum provides that both parties to the agreement will implement initiatives to slow the growth of utilization (Article 8.4). However, under the terms of the Framework Memorandum, the government has agreed to suspend its power to prorate physicians' fees for the life of the extended Master Agreement. Accordingly, prorationing is not to be used to recover any over-expenditure occurring as a result of services provided during the 1999/00 and 2000/01 fiscal years.

The BCMA, pursuant to Article 8.7 of the Framework Memorandum, has agreed to take responsibility for any over-expenditure of the available amount to a maximum of $10 million. The Framework Memorandum specifies that the BCMA is responsible, to the $10 million limit, to implement initiatives including organized reductions in office hours and facilities or other reductions in service. The BCMA must have the agreement of the government and the MSC before implementing any such reduction in service. However, if the government or the MSC refuses

agreement to the implementation of these initiatives, the BCMA will be relieved of its obligation to fund the $10 million.

In addition to these specific provisions regarding funding and responsibility for managing the available amount, the government and the BCMA have also agreed to a new conceptual framework for the negotiation of their agreements. The rationale behind the development of this new framework is set out in Article 4.1 of the Framework Memorandum:

> 4.0 Conceptual Framework for Negotiations
>
> 4.1 In the course of negotiations it has been agreed that it is in the interests of the parties to establish a process to integrate the various agreements that exist between the Government and the BCMA and groups of physicians in a manner that is more rational than the current system.

The Framework Memorandum provides that the Master Agreement will be negotiated in order to provide an "umbrella" for the overall relationship and other agreements. In addition, it provides that a working agreement will be negotiated that will address the issues of compensation, reserve accounts, on-call issues, physician benefit plans and any other issues which the parties agree upon. If the parties are unable to negotiate a new working agreement by March 31, 2001, a three person arbitration board will be established to mediate between the parties and if no agreement is reached with the help of the arbitration board, then the board has the authority to hold a hearing and to issue a final and binding award on the outstanding issues.

In the event an arbitration board is convened, the government and the BCMA will each appoint one member and the third member will be appointed by their mutual agreement. If such agreement is not achieved, either party may apply to the Chief Justice of the Supreme Court of British Columbia to make the appointment. The third appointee will act as the chair of the arbitration board.

Article 4.2.6 of the Framework Memorandum provides that the terms of reference of such an arbitration will include:

> ...the objective of being consistent with the law and the terms of the Master Agreement, reflecting the financial circumstances of government, the need to provide reasonable compensation to the physicians for the services rendered, and the operational and medical resource needs of the Health Authorities.

With respect to alternative payment plans, the BCMA and the government agreed to a process to be followed for transferring funds from the available amount to the Alternative Payments Branch to fund such plans. This process is set out in Article 9 of the Framework Memorandum.

9.0 Transfers To and From the Available Amount

9.1 The Available Amount is the amount of funding set, through negotiation or other agreed process, to pay for the delivery of required medical services to residents of the Province by fee-for-service physicians in a specific fiscal year, inclusive of the NIA and any adjustments which may be specified within a Working Agreement or the Master Agreement.

9.2 Adjustments to the value of the Available Amount(s) will occur as a result of the transfer of physicians and services to, or from, the Alternate Payments Branch. The effect of this agreement is to provide that, upon notice, the funds will be transferred to the Alternate Payments Branch subject to the ability to submit any disputes with respect to the transfer to expedited arbitration under the Commercial Arbitration Act.

9.3 The amount of the adjustment will equal the value of the payment to the affected physician for the provision of the identified services in the twelve months immediately preceding the effective date of the transfer of the physician and the services.

9.4 Where the physicians providing the services have retired, moved to another location, or voluntarily withdrawn from providing the services, the condition that the physician(s) transfer to the other mode of payment is waived.

9.5 Expedited Adjudication

Any disputes respecting a funding transfer will be resolved through arbitration under the Commercial Arbitration Act.

The arbitrator of such issues will be selected from the following list:

The adjudicator will issue a final and binding decision on the matter(s) in dispute within ninety days of the notice of the dispute.

Each party will be responsible for its own costs in participating in this adjudication and will share equally all other costs of the adjudication.

Subsidiary Agreement for Physicians in Rural Practice

The government and the BCMA's commitment to addressing issues surrounding physicians in rural practice is further reflected in the Subsidiary Agreement for Physicians in Rural Practice which was reached on June 9, 2000. This agreement, which is in effect from June 1, 2000 to March 31, 2001, contains additional provisions designed to address the unique concerns of rural physicians during the period between the commencement of the Framework Memorandum and the conclusion of a new Working Agreement. The Agreement addresses issues such as the Continuing Medical Education Program, the rural locum program, and on-call payments to physicians. As well, the agreement established a joint standing committee on rural issues which has been in the process of considering a re-evaluation of the NIA program.

Second Master Agreement

On November 23, 2000, the BCMA, the provincial government and the Medical Services Commission reached a tentative agreement on the terms of the "Second Master Agreement". This agreement is yet to be ratified by either the government or the members of the BCMA. If ratified, the agreement will come into force on April 1, 2001 for a term of five years.

Like the Framework Memorandum, the Second Master Agreement provides for a working agreement which addresses all matters of common interest to physicians and subsidiary agreements addressing those matters of unique interest and applicability to the following:

- specialists
- general practitioners
- salaried physicians
- physicians providing services on service contracts
- physicians providing services on a sessional basis
- physicians practicing in rural areas

It also provides that the government and the BCMA will periodically review the number and structure of any subsidiary agreements with a view to ensuring that they appropriately address the needs of the parties. Changes, as agreed, will be implemented in the renegotiation of working agreements.

If the parties are unable to agree on the terms of a new working agreement or subsidiary agreement(s) within the times provided under the Master Agreement, either the government or the BCMA may refer the matters in dispute to binding arbitration by a single arbitration board.

The Second Master Agreement addresses means to reduce the likelihood of disruptions of service.

The Second Master Agreement also provides for the continuation of the NIA program. However, any modification to the existing program will be negotiated as part of the subsidiary agreement for rural physicians.

Future Bargaining Between the Parties

It is intended that bargaining of the Working Agreement and each of the subsidiary agreements will occur over the same period of time. Negotiations over each of the subsidiary agreements will carry on until a tentative agreement is reached or the parties reach an impasse. In the event of an impasse, the parties will refer

outstanding issues to the arbitration board as provided for under the Master Agreement. If required, a single arbitration panel will be appointed to assist the parties in resolving the Working Agreement and subsidiary agreements. The parties have agreed that if necessary, the arbitrator may hold separate hearings on each of the subsidiary agreements.

Regional Health Authorities

On April 1, 1997, the Ministry of Health transferred authority for the delivery and management of most health services to regional health authorities. Under regionalization, the government created 11 regional health boards in urban/semi-urban areas where hospitals are located and 34 community health councils in rural areas to serve smaller and more disbursed populations.

This regionalization of health care, for the most part, is governed by the *Health Authorities Act*, R.S.B.C. 1996, c. 180.

Section 5 of the *Act* outlines the purposes of a Regional Health Board as follows:

(a) To develop and implement a regional health plan that includes:
   i) the health services provided in the region
   ii) the type, size and location of facilities in the region
   iii) the programs for the delivery of health services provided in the region
   iv) the human resource requirements under the regional health plan and
   v) the making of reports to the Minister on the activities of the Board in carrying out its purposes;

(b) To develop policies, set priorities, prepare and submit budgets to the Minister and allocate resources for the delivery of health services in the region under the Regional Health Plan;

(c) To administer and allocate grants made by the government for the provision of health services in the region;

(d) To deliver regional services through its employees or to enter into agreements with the Government for the delivery of those services;

(e) To exercise the powers and perform the duties of a council in those parts of the region for which there is not a council established under this Act;

(f) To develop and implement regional standards for the delivery of health services in the region; and

(g) To monitor, evaluate and comply with provincial and regional standards and ensure delivery of specified services applicable to the region.

In addition to the regional health boards and community health councils, the government created seven community health services societies incorporated under the *Society Act,* R.S.B.C. 1996, c. 433. These encompass a number of overlapping community health councils. Members of the community health services societies are comprised of members of the community health councils within their area.

The regional health boards and community health council's have a public nomination process and submit their recommendations to the Minister for his or her consideration. The members are ultimately appointed by the Minister. There are 15 members on a regional health board and include, in addition to members of the local community, a physician representative, a union representative and an aboriginal representative.

While most health services are managed regionally, the Minister of Health retains ultimate authority and responsibility for the health care system in British Columbia. Moreover, the Legislature sets the global budget for health care and the Minister determines the amount to be allocated to each region.

With regionalization, most health care services have merged into one umbrella administrative structure. Acute care, continuing care, home care and services for mental and public health are administered under one governing body. Diagnostic and laboratory services function as a singular entity despite the many different areas in which they are located. The goal is to have better integration of health services and growth in inter-disciplinary health care management of the community.

Under regionalization, regional health boards, community health councils and community health service societies have replaced the traditional hospital board structures. Regional Medical Advisory Committees ("RMACs") have been established with the mandate to report to each regional health board and community health council.

Doctors communicate with regional health boards and community health councils through regional medical advisory committees, individual hospital medical advisory committees and other unique structures. Many health regions report that through these committees, physicians have worked well with their health regions in identifying key issues and determining needs and priorities of the community.

Withdrawals of Service

Incidents of Withdrawal of Services

Prince George

In the north, there is serious difficulty attracting and retaining doctors. Historically, these regions have attracted doctors only when other communities were at "full capacity". The perception of northerners is that this problem has not received enough attention from the Ministry or, to some extent from the BCMA.

A few years ago, doctors in Prince George formed the Northern Medical Society in response to a growing dissatisfaction among local physicians with the nature and extent of their representation by the BCMA.

When the problem of attracting and retaining doctors in Prince George became more serious, the Northern Medical Society wrote letters to the government outlining its concerns. Because the doctors were not satisfied with the response to their concerns, they developed a task force to aid in the attraction and retention of physicians. The task force made recommendations and presented them to the Regional Health Board and the hospital administration. Both bodies endorsed the recommendations.

There were numerous subsequent meetings regarding these recommendations and other outstanding issues between the Ministry and the doctors. The doctors were not satisfied with the outcome of these meetings. Eventually a mediator was selected to assist the Northern Medical Society and the Ministry in resolving the problems. However, mediation efforts were unsuccessful. The government then offered to have outstanding matters resolved by binding arbitration, but the Society refused that offer. The Society believed that withdrawing services was the only way to have addressed what, in their view, were critical problems.

Ultimately, following a one-week service withdrawal in June 2000, the Northern Medical Society and the government negotiated an agreement outside the existing bargaining structure. The government agreed to provide $10 million targeted solely for doctors in Prince George. The ensuing agreement provided $5.2 million in extra

funding for retention, largely structured as a premium in addition to fees. It also included $3.2 million for on-call payments and locum coverage and smaller amounts for bonus money for new recruits and medical training.

Williams Lake

As was the case with the formation of the Northern Medical Society, the Williams Lake Medical Society was created to represent doctors in the Williams Lake area as a result of concerns among local physicians about their representation by the BCMA.

Following the agreement reached in Prince George, doctors in Williams Lake decided to withdraw their services. The walkout lasted for three days. An agreement, structured similarly to that reached in Prince George, was concluded. It provided approximately $1.7 million for recruitment, retention, education and on-call services. This agreement was also negotiated outside the existing bargaining structure.

After the agreements with doctors in Prince George and Williams Lake were finalized, the Ministry of Health decided that in the future it would conduct any further negotiations over like matters with participants at the bargaining table, on a province-wide basis. Further, the Ministry, in an attempt to respond to concerns raised by the northern regions, established the Physician Recruitment and Retention Program for Rural and Small Urban Communities. However, this program had terms and conditions which individual doctors found to be unacceptable.

Quesnel

Many doctors in Quesnel were not pleased with the agreements reached in Williams Lake and Prince George. Some Quesnel physicians were members of the Northern Medical Society and had anticipated that their interests would have been represented by the Society during any negotiations with the government. Not only did the Quesnel doctors feel that their health care delivery issues were the same as those in Prince George and Williams Lake and should therefore receive the same treatment, they had a growing concern about the effect of the Prince George and Williams Lake agreements on Quesnel's ability to attract and retain physicians.

The Quesnel doctors and health council attempted to reach a solution to this problem without a service interruption. However, these were unsuccessful and the specialists walked out on September 8, 2000 and were later joined by general practitioners. Largely because of the support shown in their community, the doctors returned to work without an agreement at the end of October.

Quesnel doctors did not feel there was an adequate response to their concerns. They questioned the level of trust and respect in the government/physician relationship. Quesnel doctors refused to participate in the mediation process chaired by Allan Hope, Q.C., which was agreed upon by the government and the BCMA.

Cranbrook

In July of this year, the doctors in Cranbrook served the Ministry of Health with notice of their intention to withdraw their services. The issues of concern included capital funding for equipment, compensation for on-call coverage and a desire on the part of physicians to have Cranbrook Hospital designated as a "regional" hospital. The Ministry of Health came to Cranbrook to meet with the doctors and the region. There were three meetings, all of which proved unsuccessful in reaching a solution.

There were two separate walkouts by the physicians in Cranbrook. The specialists withdrew their services from August 1 to August 12, 2000 (with the exception of services relating to life and limb threatening conditions). The general practitioners were to join them on August 8. However, there were ongoing discussions with the Ministry and it appeared that a solution might be reached. Meetings between the parties following the initial return to work on August 12 proved unsuccessful, and general practitioners and specialists withdrew services from September 12 to October 2. They returned to work on October 2 because of the commitment by all parties to engage in a process of mediation.

Since that time, there have been other withdrawals or restrictions on services provided. However, the Ministry and the Cranbrook Health Council have met with the doctors and it is anticipated that the concerns voiced by the doctors will be resolved.

Other Withdrawals

Withdrawals of service on a smaller scale have also occurred in Kamloops (summer of 2000) and Vernon (October 30 to November 10, 2000) primarily because of concerns, on the part of general surgeons, associated with the availability of operating room time.

Recently, other withdrawals and service reductions have been threatened in both rural and urban communities in British Columbia.

Mediation Panel

In an effort to resolve issues of recruitment and retention of physicians in certain rural and smaller urban communities, the government and the BCMA agreed to a mediation process. A three-person mediation panel (the "Panel"), chaired by Allan Hope Q.C., was appointed and the mediation was convened in October 2000. As a condition of the mediation, doctors agreed to suspend all interruptions of services that were related to recruitment and retention issues in the affected communities. Doctors from Quesnel chose not to participate in the mediation.

The outstanding issues before the Panel were as follows:

(a) the appropriate structure and value of the retention premiums in rural and small urban centres;

(b) the appropriate structure and value of on-call payments for physicians in rural areas and smaller urban communities;

(c) doctor of the day compensation; and

(d) the appropriate method to ensure that each physician who receives any benefit under the agreement will be bound to comply with the agreement terms and not take action designed to restrict access to the medical services covered in the agreement.

Notwithstanding the assistance of mediation, the parties were unable to achieve a resolution of the issues. Therefore, on November 24, 2000 the Panel issued its report, which included non-binding recommendations to the parties. In the report, the Panel

notes that issues which arose in the mediation will also arise in the pending negotiations of the Subsidiary Agreement for Physicians in Rural Practice. Those negotiations provide for binding arbitration as a potential means to resolve the continuing disputes. The Panel urged that doctors continue to refrain from withdrawing services pending the renewal of the Rural Agreement. At page eight of the report, the Panel writes:

> As stated, we recommend that the Doctors maintain the status quo (the continued delivery of necessary medical services in the communities affected) ...pending the renewal of the Rural Agreement. The Panel sees it as being in the interests of all concerned to maintain the status quo until the issues raised by the Doctors can be addressed in a negotiating format which has binding arbitration as a potential means to resolve continuing disputes. In return, as we will detail later, the Panel recommends that the Government make available the premiums outlined in its proposal.

In short, the Panel recommended that the government's proposal for premiums for recruitment and retention, on-call, and doctor of the day be available to the communities in return for a commitment by their doctors not to withdraw services. It recommended that the government pay the amounts necessary for such premiums to the applicable regional health boards and those boards be responsible for allocating the required payments to the physicians.

As well, the Panel recommended that a contingency fund of $3 million be established to offset circumstances where a community faces the loss of specialists seen as essential to the continued integrity of patient care. The funds are to be disbursed by the Joint Committee of the Rural Agreement and any disputes arising may be referred to Allan Hope, Q.C., for final and binding resolution.

The estimated total annualized cost of the Panel's recommendations is $40.9 million.

The government announced on December 8, 2000 that it was prepared to accept the recommendations of the Panel. The BCMA was still reviewing its response at the time of the publication of this report.

College of Physicians and Surgeons of British Columbia

The College of Physicians and Surgeons is a statutory body that was originally established by the Provincial Legislature in 1886. It continues under the *Medical Practitioners Act*, R.S. 1996 c. 285. The College is responsible for governing the medical profession in the province. Its statutory duty is to protect the public and to exercise its responsibilities in the public interest. It is responsible for the licensure of physicians and for superintending the practice of the profession. This includes establishing, monitoring and enforcing ethical standards and standards of competence and taking disciplinary action if those standards are breached.

The College is entirely separate and distinct from the BCMA. The College plays no role in the negotiation of physician remuneration or the relationships between the BCMA, individual physicians, and the government. Further, its mandate does not include dealing directly with the issue of physicians' collective withdrawals of service. However, because the College is responsible for reviewing the ethical conduct of the profession for the protection of the public, it becomes involved when physicians are threatening to withdraw, or are in fact withdrawing, their services.

The College has issued a policy statement to all practicing physicians in the province dealing with the question of service withdrawals. In it, while the College states that it believes that physicians have a right to withdraw services under specific circumstances, it also makes it clear that the College is of the view that discontinuing services to existing patients without arranging alternative services or providing reasonable notice is unacceptable. The overriding ethical principle is that patients should not be caused harm, and the College expects physicians to adhere to this ethical principle.

During threatened or actual withdrawals or limitations of service, the College monitors the situation in communities by communicating with local physicians, hospital chiefs of staff, and administrators to deal with patient access to care concerns, and where possible, to resolve difficulties. To date, the College has not received any complaints attributable to physicians' withdrawal of services.

The Commission was advised by representatives of the College that, in the College's view, there are extensive, longstanding and significant problems with the health care system in British Columbia and the delivery of medical services. The College stated that physicians' curtailment of their services is a symptom of system wide problems that have significantly impaired the ability of physicians to provide medical services required by the public. Finally, the College told the Commission that solutions to these problems will require an extensive and comprehensive review of all issues which relate to the delivery of medical and health care services, and warned that because the problem is multifaceted, if it is not approached comprehensively, it is unlikely to be resolved in a manner which best addresses the public interest.

The College clearly stated to the Commission that, in order for a meaningful relationship to exist between the College and the Ministry, there must be a method to ensure ongoing discussion between them on all service delivery issues. Currently, while the College does have official or designated persons with whom it liaises within the Ministry, it has experienced difficulties in obtaining responses from the Ministry with respect to a number of initiatives. In its view, one reason for the lack of responsiveness from the Ministry is the numerous changes in senior Ministry officials over the past years.

This turnover has hindered the ability of the Ministry and the College to develop a meaningful working relationship. More stable relationships with senior Ministry officials would be of considerable assistance in fostering and maintaining lines of communication between the College and the Ministry. The College would welcome the opportunity to develop and sustain a more positive, constructive and consistent relationship with the Ministry of Health.

As a result of its statutory role, the College has considerable valuable information and expertise regarding the situation of physicians and the delivery of medical services in the province. The College has requested that its perspective as the governing body for the profession be considered in any ongoing review of the existing problems in the health care system.

Legal Principles Concerning Withdrawals of Service

The withdrawal of medical services by doctors presents a great challenge to the achievement of a harmonious contractual relationship between doctors and the government. It appears that some doctors, and at times also the BCMA and the College of Physicians and Surgeons, have maintained that doctors have a "right" to withdraw services as a bargaining tactic. A review of the relevant legal principles in this area suggests that this position is problematic on both an individual and a collective level.

Most doctors who practice on a fee-for-service basis are not employees of the government, but rather, are viewed as independent contractors who provide services to the public and are reimbursed by the government. The fact that they are independent contractors, however, does not mean that they have an unfettered right to withdraw their services. Notably, where they have agreed to provide certain services, such a withdrawal could be a breach of contract, enabling the injured party to sue for damages. However, even where the withdrawal of services is not a breach of contract, it could still be illegal where it is done in concert with other doctors. Our legal system has always imposed limits on the ability to use collective action to achieve economic ends. The most obvious examples of such restrictions are in competition law, the common law tort of conspiracy and labour relations law.

Alternative Methods for Physician Remuneration

Alternatives to fee-for-service remuneration has been of interest to both the government and physicians for a number of years. Within the Ministry, the Alternative Payments Branch (the "APB") is dedicated to overseeing alternative methods of payment for doctors. In part, this branch exists in response to a growing number of doctors who have become dissatisfied with the fee-for-service model and wish to be remunerated under an alternate payment plan.

In particular, some recently graduated physicians have less interest than older physicians in the entrepreneurial aspect of fee-for-service medicine. They are drawn by the security of having a salary or service contract. Many of these physicians have less ideological concerns about maintaining fee-for-service as a symbol of professional autonomy, and are more willing to be reimbursed under alternate payment plans.[20]

As well, many established physicians are dissatisfied with fee-for-service because of the relative lack of rewards for some types of high quality and necessary care (e.g. the care of frail elderly, hospitalized patients, home-bound patients), and the lack of a secure income (i.e. effect of prorationing of fees).

Under Regional Programs, the APB is responsible for promoting alternative payment programs ("APP") and providing funding to regions so that regional health boards can enter into service contracts or other payment arrangements with doctors. If requested to do so, the BCMA will represent doctors in the negotiation of alternate payment plans including service contracts. As well, the BCMA will act as a resource and provide advice to physicians wishing to represent themselves.

Alternative payment plans have existed for quite some time. Throughout the province, there are a number of such plans in place. Generally, physicians or groups of physicians will contract their services to hospitals, health authorities, agencies and/or the Ministry. Alternative payment plans often take the form of service

[20] *Supra*, note 3 at 181.

contracts which provide that a physician will supply a guaranteed level of service in exchange for a specific income.

In British Columbia, the APP budget is equivalent to roughly 7 percent of the MSP budget. About 103 agencies and/or health authorities are funded by the APB at about 500 sites around the province. Ten agencies receive approximately 71 percent of the APP budget. In all, approximately 2,000 physicians receive some or all of their income through APP funded agencies.

Currently, funding for alternative payment plans comes from money transferred from the available amount, which is allocated for fee-for-service payments. The Framework Memorandum outlines the process that is to be followed for transferring funds from the available amount to the APB.

Under the terms of the Framework Memorandum on the transfer of funds, the Ministry is restricted in the number and type of alternative payment plans it can establish. This is because funds to support such programs may only be established when an individual physician is willing to convert to a different payment mode and to care for the same patients, or a physician has retired, moved to another location or has voluntarily withdrawn from providing services. Unless physicians are willing to provide services under an alternative payment plan, the Ministry can do nothing to establish such programs in situations where the population may be better served by them.

Service contracts and other alternative payment plans can offer a number of advantages. For example:

- appropriately remunerate required services that are currently poorly covered or not at all covered by a fee-for-service item
- provide a greater level of certainty, clarity and security to both physicians and hospital/regions as to their expectations of each other
- provide a stable and sustainable physician workforce in areas of the province where there is insufficient population to support a fee-for-service practitioner

- provide the flexibility and consistency both physicians and hospitals require in a changing health care system
- provide a more predictable rate of income for physicians
- provide more reasonable compensation than is available on a fee-for-service basis for certain time-consuming services
- provide compensation for indirect client care (e.g. telephone consultation, client conferences with a multidisciplinary team) as payment is not linked solely to client visits/procedures
- address retention and recruitment issues by having nationally competitive and stable service contracts that are attractive to physicians who are presently practicing, or considering practicing, in British Columbia hospitals

Despite these potential advantages of service contracts, regional health authorities and hospitals advise that the negotiation of such contracts has, until now, been fraught with challenges. Specifically, they cite the following:

- the APB has not been able to commit to the necessary resources (human and monetary) to complete competitive agreements with physicians
- the APB needs to better understand and support the need for nationally competitive levels of remuneration for specialist physicians
- there has been a difficulty in evaluating and compensating the significant components of teaching, research, administration and acuity/complexity in academic tertiary referral centres and which are not currently part of the fee schedule. APP agreements with teaching hospitals stipulate that "the use of the [APP] funds for services other than those specified or for research and teaching activities in excess of 15 percent, is a breach of the agreement." The BC Cancer Agency is an exception to this in that 25 percent of certain contracts is allowed to be used for research and teaching
- there are currently rigid formulas dealing with funding and information that make it difficult to negotiate service contracts

Due to the demand for higher incomes, some regional health authorities have had to "top up" the salaries of physicians out of their own funds, in order to secure the much needed service contracts.

The Ministry understands that physicians may be frustrated with provisions in service contracts that require them to record what their billings would be if they were being remunerated under the fee-for-service model. Many physicians choose alternative payment arrangements because they are freed from the administrative difficulties associated with billing. In many circumstances, "shadow billing" is an important means for the Ministry to determine the amount of money that needs to be transferred from the available amount to fund alternative payment plans. Moreover, there are few standards available on what data should be collected to assure appropriate levels of productivity. Developing new data systems is an evolutionary process which may require continued collection of "outdated" data as new systems are adopted.

The Ministry is also addressing the issue of comparative rates for physician remuneration under alternative payment plans. The Ministry is working on a strategic compensation framework that will assist it in providing more consistent funding and benefit rates for physicians providing similar services in similar situations.

There are many examples of alternative funding arrangements in place in hospitals and communities throughout the province. However, the following two examples of the Vancouver Hospital and Health Sciences Centre ("VHHSC") and the BC Cancer Agency provide an overview of the potential for alternative funding arrangements in tertiary care and community settings.

Vancouver Hospital and Health Sciences Centre

Recently, VHHSC and its specialty surgeons and anaesthesiologists have been negotiating over the implementation of service contracts in an effort to address remuneration issues that are unique to teaching hospitals. Specifically, doctors have identified three remuneration issues that require attention.

Teaching issues

Surgical cases at VHHSC take longer because while performing surgeries, surgeons are involved with teaching duties. The additional time taken to perform surgeries, and hence the reduced number of surgeries that can be performed in a set period of time, is not reflected in the fee-for-service model of payment.

Nursing shortages

Nursing shortages have begun to have a significant impact on service levels at VHHSC with operating room hours, ICU access and bed access falling well below planned levels. The result has been the cancellation of surgeries and a need to divert patients away from VHHSC. This, in turn, has resulted in decreased fee-for-service billings for surgeons.

Administration

As a result of cancelled surgeries and reduced access to operating rooms, beds and critical care services, surgeons are increasingly spending more time making alternate arrangements for their patients and less time providing direct care. The fee-for-service model of payment does not compensate surgeons for the time spent handling such administrative matters.

VHHSC believes that these are serious issues which need to be addressed. It believes that offering service contracts that reflect the value of research, education and practice is the most effective means of addressing these issues.

VHHSC has been negotiating with the various specialty groups of surgeons and anaesthesiologists. The objective is to establish service contracts between groups of specialists and the hospital. Pursuant to the contract, the specialty group will agree to provide administrative, teaching, research and clinical services (including on-call coverage, holidays, professional development leave and replacement, etc.) to the hospital. In particular, the group will provide clinical services to an agreed upon number of cases per year and, similarly, teaching, research and administrative

services according to an agreed upon schedule. In return, the hospital will pay the group a base-funding amount per year in lieu of fee-for-service billings. In addition, the hospital will commit to the provision of the resources necessary to provide services specified, including operating room time and patient beds, ambulatory clinic resources, supplies, hospital systems, etc.

Each specialty will be responsible for ensuring there are sufficient numbers of physicians to provide the contracted services. Moreover, the specialty group itself will control the allocation of resources to its doctors. Doctors will remain as independent contractors and maintain professional autonomy and accountability in all medical decision-making respecting patient care.

The Ministry, in recognition of the unique circumstances surrounding remuneration of physician services in teaching hospitals, has given approval for the continued negotiation of these service contracts. Funding for the service contracts will come through the APB. It is intended that similar contracts will be developed with remaining teaching hospitals under the Vancouver Regional Health Board.

While the BCMA has been present during the negotiations of these contracts, it has not been officially represented. Rather, the BCMA has served as a resource and spokesperson for the doctors, when asked.

Service contracts are well established in teaching hospitals across Canada, including VHHSC. New contracts reflecting the value of clinical services, academic, research and administrative duties are viewed by some as having the potential to more appropriately remunerate physicians in teaching hospitals.

BC Cancer Agency

The BC Cancer Agency is mandated by the government to provide a full spectrum of cancer control services to the public of British Columbia. It has had physician service contracts and salaried positions through the APB since the early 1990s. Currently, the Agency contracts for 150 full-time equivalent ("FTE") specialists such as radiation, medical and haematological oncologists providing patient care services

in four cancer centres throughout the province. The physicians are remunerated on an alternative payment basis.

Discussions over salaries and service contracts for the BC Cancer Agency doctors occur as follows. Representative groups of physicians meet with agency senior executives to address issues respecting remuneration and other terms and conditions of employment. Then, with the input of doctors, the senior executives meet with the APB to negotiate a service contract. To determine the level of funding for service contracts and salaries, the parties rely, in part, on systems in place for monitoring the number and type of services provided to patients. That is, annualized data is used each year in a physician allocation model/formula that determines resources required for the following year in core medical specialty groups. As well, national salary comparisons in the core oncology specialist groups are made at least once per year and this information is also shared and discussed with the government in relation to attraction and retention of staff. Once the level of FTE funding is determined, the funding contract is itemized according to the allocation of resources to the specialist groups, as well as the salary rate per FTE. As the BC Cancer Agency is recognized as an academic/teaching organization, the Alternative Payment Program contract recognizes and allocates time for education and research activities.

Upon receiving the funding contract, the BC Cancer Agency is responsible for dispersing the allocated funds. Although the Agency remains accountable to the APB, it negotiates the terms and conditions of individual service or employment contracts with physicians. For the most part, the doctors do not seek the assistance of the BCMA in these negotiations.

The BC Cancer Agency is seeking innovative ways to keep physicians' salaries competitive. For example, it is creating professional service agreements with incorporated physicians and partnerships. Also, the Agency is considering ways to ensure that funding contracts consider the complexity of cancer care as well as the need to provide consultative support in a growing number of communities.

Notwithstanding the difficulty in remaining competitive, the BC Cancer Agency advises that there are several advantages to having physicians remunerated on a

salary or service contract basis. These alternative forms of payment provide certainty in budget planning and lower administrative costs. As well, physicians practicing under alternative payment plans tend to be more involved in planning, policy guideline development and academic matters, in conjunction with increasingly complex core patient care responsibilities. The BC Cancer Agency has found a high level of compliance with clinical practice guidelines by their physicians. Overall, these arrangements have provided solid support for the public of British Columbia.

Bargaining Structures in Other Provincial Jurisdictions

Alberta

In Alberta the current agreement between the government and the Alberta Medical Association (the "AMA") establishes a hard cap until the 2000/01 fiscal year. To ensure the hard cap is not exceeded, the agreement provides for across-the-board reduction of fees to a set level. Despite this fact, although over-expenditure has occurred, the government has never resorted to fee reductions as a cost-saving mechanism. Instead, the government has provided additional funding to the medical services plan to cover all payments to physicians.

Provincial negotiations over the Alberta Master Agreement, which includes the hard cap and fee increases within the hard cap, are conducted between the AMA and a government team. Some physician expenditures are not covered by the hard cap and therefore are negotiated separately. For instance, remuneration levels for pathologists are the responsibility of the regional health authorities. The AMA can represent pathologists at these discussions if asked to do so.

Ongoing consultation between the physicians and the government occur through a number of joint committees. For example, the Joint Alberta Health and Wellness and AMA Finance Committee oversee the whole agreement including the budget. As well, the Alternate Payment Plan Subcommittee oversees alternate payment programs and initiates new ones.

The Master Agreement does provide for final and binding arbitration by either a board or by a single arbitrator. Nonetheless, the parties have never resorted to binding arbitration.

In early December, doctors in Alberta used job action to pressure the government to quickly grant its demands for fee and budget increases totaling 57 percent. A number of doctors in hospitals surrounding Edmonton closed their clinics for a period of three days over a weekend. At the time of the writing of this report, further job action

was planned and the government was seeking a settlement from an independent arbitrator.

Saskatchewan

Negotiations for a new contract are ongoing in Saskatchewan. However, the previous agreement did provide a soft cap on physician expenditures where the government would absorb the first one percent and additional over-expenditures would be shared equally between the government and the physicians. In the mid-1990s, the government actually paid physicians an additional 0.6 percent; however, approximately the same amount was recovered from physicians in 1999. Over-utilization has not been a problem as generally it remains consistent at one percent annually. Saskatchewan's yearly budget for physician services is based on the previous year's expenditures with a negotiated percentage increase over that amount. If parties are unable to reach an agreement, a binding arbitration process is in place but it has not been used since the late 1980s.

Alternative payment plans are negotiated between the province and doctors and/or the various districts that exist throughout the province. In some instances, the province provides funding to the districts to pay physicians under the plan. In addition, there are 18 primary care demonstration projects underway.

A commissioner has been appointed in Saskatchewan to review the structure and sustainability of the health care system. Since the commissioner has been given broad terms of reference, it is uncertain whether the bargaining structure between government and physicians will be addressed.

Manitoba

Since 1998, there have been no expenditure caps in place for either the global fee-for-service budget or individual physicians. When the government and the Manitoba Medical Association (the "MMA") were unable to reach an agreement in 1998, an arbitration panel was appointed. It decided that there would be no expenditure caps in place for the life of the agreement. The present agreement expires in March 2002.

Seventy percent of the budget for physician services is allocated to fee-for-service. The remaining 30 percent is allocated to alternate funding programs. Generally, specialists and general practitioners in rural and northern areas are compensated through alternative payment plans.

Negotiations with the MMA occur on a provincial level. While Manitoba has regional health authorities, they are not involved in the negotiations over physician remuneration. With respect to on-call funding, a contract exists between MMA and the government that provides for funding to the regional health authorities. The regional health authorities will then distribute the funds to specialists as provided for in the agreement.

Manitoba has not experienced withdrawals of service. The Master Agreement provides that in return for interest arbitration, physicians will not withdraw their services. Several matters have recently gone to interest arbitration and by agreement of the parties, the three-member arbitration panel has had broad jurisdiction to deal with issues that have arisen with respect to physician remuneration.

Ontario

In 1997, through a negotiated agreement between the government and the Ontario Medical Association (the "OMA"), Ontario established a new joint management committee known as the Physician Services Committee (the "PSC"). The Committee consists of five members appointed by the OMA and five members appointed by the Ministry of Health and Long-Term Care (the "MOHLTC"), all of who are expected to adopt roles of leadership in the performance of the PSC mandate. The PSC is chaired by a professional facilitator chosen by the parties.

The PSC meets twice a month to address matters arising under its mandate. The mandate for the PSC includes the following:

- to build and sustain a strong positive working relationship between the Ontario government and the medical profession
- to advise the MOHLTC and the OMA in connection with the changing role of physicians within the health care system, including

possible improved models of delivery of and compensation for services

- to work together toward identifying efficiencies and maximizing return on the funding provided for medical services
- to review utilization on a monthly basis and recommend to the MOHLTC and the OMA appropriate and effective steps to be taken to deal with utilization changes
- to review any disagreement arising out of the agreement between the OMA and the MOHLTC referred to it by either party and to make recommendations to the parties regarding the resolution of the disagreement. However, the parties need not make such a referral as a pre-condition to commencing any other dispute resolution mechanism
- to monitor the impact of hospital restructuring on utilization and the cost of physician services

In essence, the PSC drives the implementation of the agreement. The PSC has been extremely effective in addressing issues such as utilization, alternative payment programs and physician supply. The PSC monitors system management carefully.

In April 2000, the government and the OMA reached its first general agreement (similar to BC's Master Agreement) since the introduction of the PSC. Under the new agreement, a negotiated fee increase is put in place but there is no specified global budget. Individual physician thresholds exist for both general practitioners and specialists. However, the parties agreed that certain in-hospital after-hours services would not be included in income for the purpose of calculating thresholds.

The PSC oversees a number of alternate payment programs including specific plans for emergency room doctors, northern communities, specialists and academic hospitals. These programs are negotiated and administered provincially as there has been no regionalization of health services. The number of alternate payment programs may increase as Ontario proceeds with primary care reform.

To date, Ontario has experienced only the occasional withdrawal of service. Such incidents are addressed on an individual basis. The new agreement does address many issues that were of concern to physicians such as funding for hospital on-call

coverage and patient care enhancements (e.g. low volume obstetrical incentives, admission assessments and after-hours premiums) that may assist the stabilization of physician services.

Quebec

In Quebec, general practitioners and specialists are represented separately by their own associations. Each association negotiates its own agreement with the provincial government. In the 1995/96 fiscal year, global government expenditures were frozen and the Ministry of Health adopted a fixed budget, which in turn meant that global hard caps were set in place for both general practitioners and specialists. There is no legislation in place that provides for a method of recovery. Therefore, it is by agreement that the parties determine the process for dealing with any overruns. However, there has been no recovery of cost overruns since the hard cap was established.

As noted earlier in this report, Quebec preceded all other provinces by well over a decade in implementing individual income thresholds. Specialists are subject to semi-annual thresholds for earnings received from services provided in private medical offices; however, no thresholds exist for earnings received from services provided in hospitals.

Thresholds vary by specialty, as do the allowances made for overhead. All specialists' claims over the threshold are paid at $0.25 on the dollar.

Recently, the government reached agreements with both specialists and general practitioners. The parties agreed to a global budget which allows for fee increases of 1.5 percent for 1999 and 2.5 percent each year for 2000, 2001 and 2002. For each three-month period, caps for general practitioners were raised to $50,000 and semi-annual thresholds for specialists were increased to approximately $140,000. With respect to both specialists and general practitioners, a reserve account that is funded from the global fee increase has been created for the purpose of reimbursing the government for cost overruns during the life of the agreement.

Nova Scotia

From 1992 to 1997, Nova Scotia's Master Agreement between the Medical Society and the Department of Health had fixed caps for both global budgets and individual physician incomes. Through negotiation, the parties agreed to prorationing as a mechanism to control over-expenditures. As well, restrictions were placed on billing numbers.

As a result of proration, fee structures were rolled back 1.5 percent for two quarters as of April 1, 1992. This resulted in greater peer pressure among physicians and collectively it transpired into closer control of utilization. In fact, the government entered into a surplus and physicians were given additional funds in 1993 for fee re-distribution. Key to the physicians' collective restraint of utilization was central communications from the Nova Scotia Medical Society. There are approximately 2,000 physicians in Nova Scotia. Their ability to self-regulate utilization is greater given their smaller numbers.

Since the establishment of a new Master Agreement in 1997, there have been no cost control mechanisms in place to restrain physician expenditures. As a result, physician expenditures have increased approximately 36 percent in a four-year period. As well, due to fee increases, physicians have been meeting their income expectations earlier and are less willing to work weekends and longer hours. The current agreement expires March 2001.

During the past three years, a wide variety of alternate payment plans have been put into place in Nova Scotia. Each of these plans falls under the umbrella of the Master Agreement. For instance, all physicians at academic hospitals are practicing under alternate payment arrangements that stipulate service levels. Parties to the agreement include the Medical Society, the Department of Health, the corporate practice plan group, medical schools and the hospital.

In non-academic hospitals, including regional hospitals, service contracts exist between specialty groups and the hospital, the Medical Society and the Department of Health. The specialty groups form what are referred to as corporate practice groups. All physicians in a particular specialty group must participate in the plan. It

becomes the responsibility of the corporate practice group to ensure there are sufficient numbers of physicians capable of fulfilling the service levels stipulated in the contract. The use of service contracts in non-academic hospitals has addressed the problem that remuneration under the fee-for-service model is insufficient to support physicians or a group of physicians on a regional level. Psychiatrists practicing in mental health centres as well as emergency room physicians have also entered into service contracts.

At the community level, contracts exist between the Department of Health and individual physicians. Physicians are paid a fixed amount for services delivered under a contract that either provides for the doctor or the province to assume responsibility for overhead costs. Physicians wishing to assume responsibility for their own overhead are paid approximately $155,600 annually. Physicians working out of a facility where overhead costs are covered are paid approximately $102,300 annually. Upon entering into either contract, the doctor is prohibited from withdrawing services while the contract is in place. Interestingly, there have been no service disruptions from doctors who have entered these contracts. Rather, it is the doctors who remain on the fee-for-service model who have on recent occasions withdrawn their services.

Following extensive consultation with physicians, the province has recently initiated a pilot project for the introduction of nurse practitioners in community health centres.

Prince Edward Island

In Prince Edward Island, the agreement between the government and the Prince Edward Island Medical Society provides for both global and individual expenditure caps. A soft cap exists for global fee-for-service expenditures, as overruns are funded equally by the Medical Society and the government. The Medical Society's contribution to cover over-expenditures is funded by a five percent holdback on physicians' payments.

Individual physician income thresholds exist for both general practitioners and specialists. Incomes are capped at $300,000 for general practitioners and $400,000

for specialists. Excesses are discounted at 30 percent for the first $50,000 and 60 percent for excesses beyond $50,000.

As well, physician complements are in place for various specialties as a means of limiting expenditures. For example, there is a complement of two plastic surgeons and five ophthalmologists for the province. Doctors wishing to practice in a specialty field where there is a full complement will receive only 50 percent of his or her billings.

The Medical Society has the sole and exclusive right to bargain on behalf of all its members, including for the purpose of negotiating alternate payment arrangements. Alternate payment programs exist in the form of sessionals, service contracts and salaried positions. Emergency room physicians are paid per hour on a sessional basis. Palliative care physicians are provided a guaranteed income as part of a service contract. All paediatricians, oncologists, laboratory medicine physicians and some psychiatrists are paid on a salary basis. Part II of the Master Agreement between the parties sets out the terms and conditions of all salaried physicians. Individual job descriptions are established in consultation with the employing authority and the physician.

Senior employees of the Department of Health and Social Services and the Medical Society negotiate the Master Agreement between the parties. Mediation and binding arbitration processes exist for disputes arising under the agreement or if parties reach an impasse and are unable to reach an agreement. As well, a grievance procedure exists for salaried physicians. Throughout the term of the agreement, a joint consultation committee oversees financial matters that pertain to the agreement.

Prince Edward Island has not experienced any withdrawals of service by physicians.

New Brunswick

In New Brunswick, legislation has provided for a global fee-for-service budget cap and individual income caps since 1992. Only once, in January 1996, the government decided to apply recovery for a four percent expenditure over the global cap. Since then, the cap continues to be applied but recoveries have not been made given the

identification of alternate deficit financing. The parties have agreed that if the cost of physician services exceeds the levels set in the budget cap, by mutual agreement they will determine the method of recovery.

Individual income thresholds are fixed by government according to the provisions of the governing legislation, and therefore are not subject to negotiation. They are increased yearly by the negotiated price increase applied to the global cap. Currently, a memorandum of understanding is in place that suspends the individual soft cap for two years.

The Assistant Deputy Minister of Public Health and Medical Services bargains with the New Brunswick Medical Society over matters related to remuneration. Contracts have historically been negotiated year to year. This year the parties for the first time in recent history have resorted to mediation to assist them in reaching an agreement. Pursuant to regulation, final choice binding arbitration is available if the parties are unable to reach an agreement.

New Brunswick works on a blended payment model. Physicians can be remunerated on a single payment method (fee-for-service, contract, sessional or salary) or through a mix of these payment methods according to the services provided. For contract physicians, the Medical Society will bargain on their behalf if requested.

During the past year, New Brunswick has experienced disruptions in services. Recently, doctors have implemented a program of rotating days for office closures across the province as part of an ongoing effort to pressure the government to improve working conditions and wages. Generally, disruptions have involved only small groups of general practitioners in certain regions of the province. To date, there has not been any public outcry about these disruptions as most services have merely been rescheduled for other days or performed by local emergency departments.

Newfoundland

In Newfoundland, the terms and conditions for funding for medical services are contained in a Memorandum of Understanding ("MOU") between the

Newfoundland Medical Association, the government, and the Newfoundland and Labrador Health Care Association. The latter is a parent association to the eight regional health boards that exist in the province. Prior to the MOU, which was signed in 1998, the regional health boards were not a party to the agreement that existed between the government and the Medical Association. Problems arose because of the lack of input from regional health boards which employ 30-35 percent of the physicians in the province. Thus, the bargaining structure was changed to include representation of the regional health boards. Presently, the treasury board is the signatory for the government.

Under the MOU, there are two budgets: one for salaried physicians and one for fee-for-service physicians. Expenditure caps exist for both budgets. The cap for salaried physicians is based on the number of approved salary positions throughout the province. The cap for the fee-for-service budget is based on the previous year's budget with adjustments made for demographics, physician resources and new technologies.

Regulations provide for the global fee-for-service budget cap. To keep physician expenditures within the budget, the government has used fee discounting. In the early 1990s, when fee discounting was first introduced a high percentage — approximately six to seven percent — was used. Subsequently, the percentage reduction was in the range of one to two percent when this recovery mechanism was used. The last time fees were discounted was in 1996/97. Since then, the government has carried forward the deficit that has resulted from over-expenditure.

Since the introduction of the global expenditure cap, individual income thresholds have existed for physicians practicing on the fee-for-service model. For general practitioners, the first threshold is $341,000. Excess claims are paid at $0.66 on the dollar until the second threshold of $398,000 is reached. All subsequent claims are paid at $0.33 on the dollar. For specialists, the same discounting occurs but the thresholds are $436,000 and $490,000, respectively. This method of expenditure control is provided for in the payment schedule.

For many years, salaried physicians have been part of the medical delivery system in Newfoundland. Originally, cottage hospitals located in outlying communities employed physicians. Currently, regional health boards responsible for local hospitals employ physicians for the provision of medical services. Improvements in salaries over the past few years have made salaried positions attractive for a greater number of doctors.

Since the MOU was signed, Newfoundland has experienced occasional incidents of unorganized service withdrawals. For instance, urban psychiatrists are refusing to provide on-call services at hospitals, choosing instead an office-based practice. As well, in one community family practitioners have withdrawn hospital-based services in response to an increasing workload and on-call schedule created by the gradual loss of doctors and the decision by several other doctors not to provide hospital coverage in that community.

The mechanism to address withdrawals of service is provided for in a micro-agreement to the MOU. It provides as follows:

> If there are service delivery issues associated with provision of medical services by physicians during the term of the MOU, timely discussions will be held to address this problem. If the parties cannot agree on a solution, the matter will be referred for dispute resolution [non-binding mediation] in accordance with the MOU and a decision rendered within 14 calendar days. If the parties are still unable to resolve the service delivery issue, the parties acknowledge that Government retains all the rights available to it, as if the MOU and this agreement had not been executed, to unilaterally allocate or reallocate funds to address this issue.

Further, the agreement provides that the MOU is rendered void if unilateral action is taken.

Recently, a dispute has arisen with respect to eligibility for additional on-call funding. This matter has been referred to mediation under this dispute resolution process. Reluctantly, the government has agreed that in the event mediation fails, the mediator may issue a directed opinion. However, the directed opinion will be non-binding on the parties.

Yukon

In the Yukon, the current Memorandum of Understanding (April 1/99 – March 31/02) (the "MOU") includes a soft cap. Prior to this agreement no caps had been implemented. Under the MOU, fees are decreased by a maximum of one percent in the first six months of any fiscal year to recapture a maximum of 50 percent of expenditures in excess of the soft cap in the prior fiscal year. Although an over-expenditure occurred in the 1998/99 year, which was subject to the imposition of the soft cap, the Government and the Yukon Medical Association (the "YMA") have not yet resolved recovery. There is no plan at this time to implement further cost control measures. Prorationing is by payment as defined in the MOU between the parties.

The government is in the process of developing compensation options, including more comprehensive use of alternative payment mechanisms. There are currently two physicians in the Yukon paid under alternative payment arrangements. These physicians are contracted to provide services in two remote locations.

In April 1999, two physicians in Dawson City discontinued providing services outside of clinical hours. The physicians wanted to receive compensation for being on call. Ongoing discussions between the Department of Health and Social Services and the physicians have not yet been successful. Access to after-hours services is currently provided by community nurse practitioners. Emergency cases were "medevaced" to the Whitehorse General Hospital.

Northwest Territories

The Northwest Territories does not have an expenditure cap; however, the agreement between the government and the Medical Association covering 1997 to 2000 provided for a two percent decrease in fees.

All specialists and the majority of family practitioners are remunerated through alternate payment plans. The remaining family practitioners still practice on a fee-for-service basis. While the Medical Association represents the physicians in negotiations over the master agreement, individual physicians have negotiated their own service contracts with the government. However, to maintain a degree of

consistency between the various service contracts, the government is encouraging the Medical Association to become the representative of physicians in the negotiation of these service contracts.

Nunavut

Nunavut contracts with approximately 14 doctors to provide services to the territory's population of 27,000. The executive director of each of the territory's three regions is responsible for negotiating contracts with physicians. Many of the contracts are for only short-term periods of one to two months. Doctors who sign long-term contracts or have been providing services for longer periods of time receive greater compensation for their services.

Although Nunavut has not experienced withdrawals of service, the territory has difficulty attracting and retaining doctors. Often, the government must find replacements for physicians who choose to leave for practices in southern Canada.

Nunavut relies heavily on highly skilled nurses who run outposts in remote areas. Many patients who would normally be seen by a doctor will be seen by a nurse that has a certified expanded scope of practice. Often the nurse will consult with a doctor by phone and, if necessary, the patient will be flown to hospitals in Iqaluit, Yellowknife or the south.

Submissions to the Commission

The Commission received many submissions from individuals and institutions throughout the province, including hospitals, regional health authorities, physicians and members of the public. The Commission greatly appreciates the thought and effort that has gone into each one. It is evident from these submissions that careful consideration has been given to the matters raised in the Interim Report. The following provides a summary of recurring and conflicting concerns received. It should be noted that these are not necessarily the views of the Commission, but are representative of the various points of view outlined by the respondents.

Physician Supply and Remuneration

- Once compensation is set, there should be no prorationing of doctors' fees.

- The reduced supply of physicians and nurses in British Columbia has had an adverse effect throughout the province, but appears to have had a disproportionate effect in the northern and isolated regions. As a result, physicians in those communities are working long hours without any relief.

- Outdated equipment in many facilities detracts from both the provision of quality care and the ability of British Columbia to attract and retain physicians.

- Physicians should be compensated fairly by considering the remuneration paid to physicians in comparable communities (i.e. rural and urban, academic and non-academic) both within and outside of Canada.

- In determining the remuneration of physicians the following factors are significant: increasing office overheads; inflation; taxation; closure of hospital beds; and reduced operating time.

- A system designed to address remuneration of physicians must be flexible. Furthermore, alternatives to fee-for-service are desirable, but must be equitable, easily accessible and responsive to the needs of both doctors and the regional health authorities. In order to achieve this, significant changes must be made to the current APP administered through the Ministry.

- There is a lack of physician accountability in the province. Physicians need to be held accountable for the action (or inaction) they take and for the services they deliver (or choose not to).

Improved Integration between Ministry of Health, Regional Health Authorities and Physicians

- Regional health boards submit that there should be better integration between the regional health boards, physicians and the Ministry. They advise that regionalization of health care will be more effective if physicians, who they see as gatekeepers to the health care system, are more fully integrated into the regional system. For example, to date formal bargaining of remuneration for physicians occurs primarily at the provincial level. Many regional health boards submit they have had limited involvement in this bargaining process. Many regions have suggested that rates of remuneration for doctors should continue to be bargained at a provincial level but must consider and reflect input from the regional health authorities.

- Health authorities outline a concern over their limited ability and authority to formally contract with physicians directly, at the regional level, for the provision of health care services. They perceive themselves as having "responsibility without authority". That is, while the regional health authorities are accountable to the Ministry for the provision of services, they feel they have insufficient authority over the physicians within the region or the manner in which those physicians deliver their services. Therefore, many regional health authorities recommended that, once rates are set at a provincial level, interested regions should be provided with the necessary

funding and authority to contract directly with local physicians for services needed by the particular community.

- Many regional health authorities perceive walk-in clinics as performing a role that works against regionalization. Walk-in clinics do not create a sense of physician responsibility to the community and provide little incentive for long-range health planning. As a result, they work against strategic health care plans being developed and implemented by the regions.

Management of Health Care Issues

- Because health care issues are often regional in nature, they need to be dealt with promptly at a local level. However, to date, many regional health boards feel that the Ministry controls and, to some extent, restricts them in their attempts to address concerns at a local level. This is an impediment to the development of a productive relationship between doctors and the regional health authorities. Submissions recommended that a vehicle be designed to allow physicians and regional health authorities an opportunity to share their respective concerns and work together to proactively implement change.

- Physicians' needs must be represented adequately and in a timely manner so that concerns are addressed and dealt with long before a withdrawal of service is contemplated or implemented. To accomplish this, physicians with distinct needs or interests should be identified and fairly represented in any bargaining structure. Examples of such groups include the following: individuals in northern or isolated regions; individuals in rural areas; and individuals in tertiary care facilities who are fulfilling a clinical and academic mandate.

- The Ministry must be responsive to issues raised by the regions regarding physicians. High turnover of personnel at all levels of the Ministry has delayed prompt and effective responses to health care issues brought to its attention.

- The Ministry should negotiate consistently with doctors in different regions of the province.

- As part of the remedy for existing difficulties within the current bargaining structure between physicians and the government, timely binding arbitration should be implemented. This would both avoid delay and remove any perception that the parties have not consistently negotiated in good faith.

Analysis and Recommendations

Introduction

Canada has an enviable public health system that is well worth preserving. The primary objective of this system, as enshrined in the *Canada Health Act*, is to provide residents of Canada with reasonable access to health care services "without financial or other barriers".

The *Canada Health Act* also stipulates that doctors are to be paid reasonable remuneration for providing medical services to the public. Doctors who are enrolled in public medical services plans do not bill their patients directly for insured services. They are paid for their services by the government. The challenge for provincial governments is to balance the public's right to doctors' services with the doctors' right to reasonable remuneration for providing patient services, within limited financial means.

Over the past decade or so, this has proven to be more difficult. Under a fee-for-service model, governments have great difficulty in predicting and containing the costs of doctors' services. There are limits to the public's ability to fund the medicare system. Provinces have a responsibility to the public to control medical costs, in part to ensure the sustainability of accessible quality medical care. Thus, governments must set reasonable parameters in budgeting the cost of doctors' services, and then work with doctors to best ensure that the governments are meeting the needs of the public within those parameters.

Prorationing is a simple method of controlling the cost of doctors' services. Through this means, budget overruns are dealt with by reducing doctors' fee values. However, the prorationing of doctors' fees in 1997/98 and 1998/99 in British Columbia had a destabilizing effect on the relationship between the doctors and the government. For the first time in the recent history of this province, doctors engaged in withdrawals of service as a means of protecting their fee values. Subsequently, when prorationing was not in effect, groups of doctors used withdrawals of service to

protest other remuneration matters and issues concerning the delivery of medical services that they believed needed to be addressed immediately by the government.

These withdrawals of service preclude certainty and continuity in the provision of patient care and are therefore not in the public interest. Furthermore, they compromise the right of the public under the *Canada Health Act* to accessible medical care.

In response to these withdrawals, the Government of British Columbia established this Commission to examine the contractual relationships between doctors and the government and to make recommendations to improve them. In the course of the Commission's research, it has become clear that withdrawals of service are not the cause of the problem with the contractual relationships between the government and the doctors; rather, they are an outward manifestation of these problems. Thus, in carrying out its mandate, the Commission has had to probe more deeply into the relationships to determine the source of the problems.

In this task, the Commission has been greatly aided by the many thoughtful submissions it has received. From these submissions, the Commission has learned about a variety of issues affecting the bargaining structure and, hence, the contractual relationships, and has arrived at the following conclusions.

Elements to be Addressed

1. For the relationship between doctors and the government to work properly, it must be built on a foundation of trust. This point was stressed by the Okanagan Similkameen Health Region in its submission to the Commission:

> In order to ensure that the bargaining structure works properly and fairly requires a level of willingness and trust between the parties engaged in the negotiation. It is incumbent on the parties to see that a level of trust and willingness to negotiate in good faith occurs. This cannot be achieved through legislation and can only be built through mutual respect and understanding.

There is a lack of trust and mutual respect at present. It will take some time and considerable effort for the parties to regain these elements essential to a positive relationship. It requires a real commitment on both sides to make the system work properly and fairly. The Ontario Medical Association and the Ministry of Health and Long-Term Care is demonstrating this type of commitment through the work of its Physician Services Committee. The Physician Services Committee consists of five persons appointed by the Ministry of Health, five persons appointed by the OMA and chaired by a professional facilitator selected by the parties.

The Commission believes that a similar committee should be established by the BCMA and the government in British Columbia. This committee should be composed of individuals not involved in the bargaining process and hence not embroiled in bargaining disputes. Its purpose should be to:

- build and sustain a strong positive working relationship
- advise their principals of changing roles of physicians in the health care system including possible improved models of delivery and compensation of services
- jointly identify efficiencies and the maximization of return on the funding provided for medical services
- review utilization and recommend to their principals effective steps to be taken regarding utilization changes
- monitor the impact of any pending restructuring in the delivery of health care

Recommendation: That a mechanism similar to the Ontario Physician Services Committee be adopted in British Columbia for the purpose of developing and sustaining a strong, positive working relationship between the doctors and the government.

2. It is self evident, but worth emphasizing, that the government must establish a sufficient budget for the provision of services by doctors. Reliable criteria are available to predict the annual costs of these services. Currently, the Medical Services Commission recommends an annual budget for doctors' services. However, the Medical Services Commission is not seen as being independent of the Ministry of Health. Therefore, doctors have not always accepted that the budget amount recommended by the Medical Services Commission is sufficient. A mechanism must be developed whereby the integrity of the budget system is respected.

   Recommendation: That a sufficient annual budget for doctors' services be determined pursuant to appropriate established criteria.

3. It cannot be denied that the government must have an effective means for establishing and controlling the budget for health care services. Doctors are vehemently opposed to the use of unilateral prorationing as such a means. They view this as undermining the bargaining process because their agreed upon fee values can be unilaterally reduced to cover budget overruns. As well, prorationing has exacerbated internal divisions within the profession as physicians vie for their share of the fixed budget. Finally, prorationing has contributed to a divisive relationship between the government and doctors. Indeed, the Commission has been informed that prorationing has caused similar problems in other provinces where it has been implemented.

   If the bargaining process is to work properly and fairly, jointly agreed upon and effective mechanisms must be developed to assist government in controlling the costs of doctors' services as a substitute for unilateral prorationing.

   Recommendation: That, as a substitute for unilateral prorationing, jointly agreed upon and effective cost-containment mechanisms be developed to assist the government in controlling the costs of doctors' services.

4. Doctors have expressed frustration with the ability of the current bargaining structure to adequately respond to their concerns. This frustration has been directed at both the BCMA and the government. Both of these parties are aware of this and are attempting to constructively respond to it. The elements to be focused on are as follows:

i) Submissions from some doctors have indicated that they do not believe the current bargaining structure adequately protects their interests. It is essential that doctors with common interests have sufficient input and control over the bargaining of their remuneration agreements under the umbrella of the BCMA.

Recommendation: That under the umbrella of the BCMA, doctors with common interests have sufficient input and control over the bargaining of their remuneration agreements.

ii) The Commission also received submissions from doctors who said they do not think that the bargaining structure has responded in a timely, coordinated and consistent manner to their remuneration issues. The Commission believes that both the BCMA and the government must organize their negotiating efforts and allocate sufficient resources to ensure that this occurs. On the government side, this may require the use of an agency to coordinate its bargaining efforts.

Recommendation: That both the BCMA and the government organize their negotiating efforts to ensure that the bargaining structure is able to respond in a timely, coordinated, and consistent manner to the remuneration issues of doctors.

iii) The Commission has heard from both doctors and local health authorities that there have been some difficulties in negotiating alternate payment arrangements. British Columbia, like many provinces and territories, has established alternative payment plans as a means of remunerating physicians. More arrangements of this nature should be encouraged in British Columbia. For example, the service

contracts being discussed for specialists at Vancouver Hospital and Heath Sciences Centre are an innovative way of addressing the challenges of remunerating highly skilled doctors for their patient services and academic responsibilities in a teaching hospital. Not only can alternative payment plans provide predictability to the cost of providing medical services, they also can assist in fashioning remedies for local issues. Therefore, the Commission is of the view that the government, health authorities and the BCMA should work together to ensure that doctors who so desire can be remunerated on an alternative basis. Such arrangements must be made under the umbrella structure of the parties.

Recommendation: That the government, health authorities and the BCMA work together to ensure that doctors who so desire can be remunerated on an alternative payment basis, within the umbrella structures of the parties.

5. Submissions from some local health authorities indicate that their issues and concerns about the provision of doctors' services are not being sufficiently considered by the government in its negotiations with doctors.

   Recommendation: That all of the bargaining processes of the government must be inclusive of input from local health authorities.

6. The Commission heard about the problems that arose because doctors in Prince George and Williams Lake withdrew services and, ultimately, in response, agreements were negotiated outside of the established bargaining structure. This encouraged doctors in other communities to attempt similar tactics to achieve the increases provided to doctors in Prince George and Williams Lake. Obviously, if this were to continue, it would have the effect of destroying the bargaining structure. This clearly is not in the best interests of anyone. A bargaining structure is intended to provide a predictable, reliable and equitable means of settling bargaining disputes. This is necessary to prevent participants from being

played off against one another and to protect the right of the public to uninterrupted access to doctors' services.

Recommendation: That the parties negotiate all bargaining matters within the established bargaining structure.

7. The Commission has heard from both the doctors and the government about the problems that have been caused in their contractual relationships because the agreements negotiated by the parties have not been respected. It is essential that the government, the BCMA and doctors be bound to the agreements negotiated on their behalf and ratified by them. No bargaining structure can work properly if the resulting agreements are not respected by all persons and entities to whom they are intended to apply.

   Recommendation: That the government, the BCMA and doctors be bound to agreements negotiated on their behalf and ratified by them.

8. The Commission has learned that the parties cannot always resolve difficult bargaining issues themselves. Therefore, the Commission believes that independent binding arbitration is required as the ultimate mechanism for settling bargaining disputes.

   Recommendation: That independent binding arbitration is required as the ultimate mechanism for settling bargaining disputes.

9. The uninterrupted provision of doctors' services is essential to the public well-being. If there is an agreed upon bargaining structure in place that contains the elements identified by the Commission, doctors should be obliged to resolve their bargaining disputes within this bargaining structure without resorting to withdrawals of service.

Recommendation: That provided there is an agreed upon bargaining structure that contains the elements identified by the Commission, doctors should be obliged to resolve their bargaining disputes within this bargaining structure without resorting to withdrawals of service.

10. It is clear from the recent withdrawals or threats of withdrawals of doctors' services that the parties must have a mechanism in their agreements for dealing expeditiously and effectively with critical and emergent issues. Continuity in the provision of patient care should not be put at risk because of the lack of an effective means to deal with such issues. The BCMA and the government should establish a joint working committee to address critical and emergent issues.

    Recommendation: That the parties establish a joint working committee for dealing expeditiously and effectively with critical and emergent issues.

11. There is a complex historical relationship between doctors, the BCMA and the government. The problems that have recently developed are a clear reflection of the need to revisit the mechanisms and processes in the bargaining structure that are currently in place to respond to issues. Doctors, the BCMA, health authorities and the government have expressed to the Commission a sincere willingness to engage in efforts to resolve the challenges before them in serving the public interest and providing certainty and continuity in the provision of patient care in this province. Everyone the Commission has heard from wants the system to work properly and fairly so as to protect the rights of both the public and the doctors. With the commitment of the parties, the Commission is confident this can be achieved.

    Therefore, the Commission does not recommend any legislative changes at this time. The parties should be given an opportunity to deal with the Commission's recommendations.

However, should the parties be unable to resolve the problems in their contractual relationships, an independent public body will be required to deal with the situation, because the public interest demands that the system for providing doctors' services functions properly and fairly for all concerned.

In that event, legislation will be required to implement the elements of the Commission's recommendations in a fair and balanced manner, and to establish an independent tribunal to oversee the application of the legislative scheme. This tribunal should be appointed by the Chief Justice of the Province and should be empowered to resolve issues arising out of the contractual relationships between doctors and the government.

Recommendation: The Commission does not recommend legislation at this time. However, if the parties are unable to resolve the problems in their contractual relationship themselves, the Commission recommends that fair and balanced legislation be enacted encompassing the elements addressed in this report, and that an independent tribunal, appointed by the Chief Justice, be established to regulate and adjudicate issues relating to these relationships.

Conclusion

The Commission has endeavoured to fashion recommendations that will be helpful to the parties in resolving the problems in their contractual relationships and to assist the Legislature in deciding how to deal with these relationships as a matter of public policy. It is in the public interest that appropriate mechanisms be established to ensure that the interests of doctors are being addressed without the need for them to withdraw their services. The Commission's recommendations are intended to achieve that objective.

APPENDIX A — Summary of Recommendations

Recommendation: That a mechanism similar to the Ontario Physician Services Committee be adopted in British Columbia for the purpose of developing and sustaining a strong, positive working relationship between the doctors and the government.

Recommendation: That a sufficient annual budget for doctors' services be determined pursuant to appropriate established criteria.

Recommendation: That, as a substitute for unilateral prorationing, jointly agreed upon and effective cost-containment mechanisms be developed to assist the government in controlling the costs of doctors' services.

Recommendation: That both the BCMA and the government organize their negotiating efforts to ensure that the bargaining structure is able to respond in a timely, coordinated, and consistent manner to the remuneration issues of doctors.

Recommendation: That the government, health authorities and the BCMA work together to ensure that doctors who so desire can be remunerated on an alternative payment basis, within the umbrella structures of the parties.

Recommendation: That all of the bargaining processes of the government must be inclusive of input from local health authorities.

Recommendation: That the parties negotiate all bargaining matters within the established bargaining structure.

Recommendation: That the government, the BCMA and doctors be bound to agreements negotiated on their behalf and ratified by them.

Recommendation: That independent binding arbitration is required as the ultimate mechanism for settling bargaining disputes.

Recommendation: That provided there is an agreed upon bargaining structure that contains the elements identified by the Commission, doctors should be obliged to resolve their bargaining disputes within this bargaining structure without resorting to withdrawals of service.

Recommendation: That the parties establish a joint working committee for dealing expeditiously and effectively with critical and emergent issues.

Recommendation: The Commission does not recommend legislation at this time. However, if the parties are unable to resolve the problems in their contractual relationship themselves, the Commission recommends that fair and balanced legislation be enacted encompassing the elements addressed in this report, and that an independent tribunal, appointed by the Chief Justice, be established to regulate and adjudicate issues relating to these relationships.

Appendix B — Individuals & Organizations consulted by the Commission

Doug Allen

G. Appleton, M.B., Ch.B., The Medical Clinic, Terrace

Anne Ardiel, Ministry of Health

Dr. Robert Arnold, Campbell River Doctors

G. Aspen, Cranbrook Health Council

Dr. Philip Asplin

Dr. Bill Asquath, Northern Medical Society

Dr. David Attewall, Society of General Practitioners of BC

Granger Avery, M.B., B.S. (London), Dip. Obst. (Auck.), Port McNeill Medical Clinic

David Babiuk, Deputy Minister CEO Focus Group

Morris Baker

Dr. Leon Bard, M.D.

Morris L. Barer, Centre for Health Services and Policy Research

Jane Barry, R.N.

Ken Berg

Merlyn Bigham, B.S.N.

Alex Black, Omineca Clinic

Dr. Doug Blackman, College of Physicians and Surgeons of BC

David Blair, B.S.P., M.D., M.H.A., Workers Compensation Board

Dr. Bluman

Bert Boyd, Vancouver Richmond Health Board

Cathi Bradbury, Newfoundland Department of Health

Dr. Paul Brown, Campbell River Doctors

John Cairns, Council of University of Teaching Hospitals

Luzand Campbell, B.S.N.

Ken Champoux, Ministry of Health

Dr. Douglas Cochrane, Council of University of Teaching Hospitals

Dr. Geoffrey Coleman, VHHSC & Council of University of Teaching Hospitals

Cathy Cordell, BCMA

Dr. M. Dahl, BCMA

Cathy Delman, Ontario Ministry of Health and Long Term Care

Keith Dennison, Nunavut Department of Health & Social Services

Derek Dinham, Nova Scotia Department of Health

Dr. Victor Dirnfeld, M.D., F.R.C.P. (C), F.A.C.A., Diplomate American Board of Internal Medicine

Dr. L. Doyle

Dr. Duncan

Jack Ebbels, Assistant Deputy Minister, Ministry of Health

Phil Ebelson, Northern Medical Society

Greg Eisler

Robert G. Evans, Centre for Health Services and Policy Research

J.S. Fair, D.H.A., F.A.C.H.E., Simon Fraser Health Region

Dr. G. Fedor

E. Gerdes, North Okanagan Health Region

Dr. David Glen, Campbell River Doctors

Dr. Ian Grant, M.D., F.R.C.P. (C)

Lorraine Grant, Health Association Board Meeting

Dr. Stephen Gray, Ministry of Health

Michael Hancock, Harris & Company

Robin A. Hanvelt, Centre for Health Services and Policy Research

Bruce Harber, Deputy Minister CEO Focus Group

Eric Harris, Q.C.

Philip Hassen, Vancouver/Richmond Health Board

Constance Heibey, WSPA

Ernie Higgs, M.D., Capital Health Region

Leah Holins, Deputy Minister, Ministry of Health

Geoffrey Holter, BCMA

Jeremiah Hurley, McMaster University

Johanne Irwin, Prince Edward Island Department of Health and Social Services

Murray Jacobs, Ministry of Health

Dr. Eric Jeffries, M.B., Ph.D, R

Michael Johnson, Council of University Teaching Hospitals

Stuart Johnston, M.B., Ch.B., M.Sc. (Civil Eng), C.C.F.P., Dept. of Family Practice UBC

Debra Kaweski, Alberta Health and Wellness

Dr. Kelly, Northern Medical Society

Brian Kines, C.E.O., Sea to Sky Community Health Council

John Knoch, C.E.O., Quesnel and District Health Council

Mike Knudson, VHHSC

Kenneth Kolotyluk, M.D., Society of General Practitioners of BC

Lawrence Krahn, Saskatchewan Health

Dr. Kurloch, Society of General Practitioners of BC

Trina Larsen Soles, Society of Rural Physicians of BC

Linsdey Lawson, M.D., C.M., M.Sc., F.R.C.P. (C), St Paul's Hospital, Respiratory Medicine and Thoracic Surgery

Peter Leckie, Section of General Surgery

Linda Lingley, New Brunswick Department of Health

Dr. Paul Mackey, M.B.B.S., D.R.A.N.Z.C.O.G., D.A.

E. MacRae, Okanagan Similkameen Health Region

M. Marchbank, Valley Health Region

Doug Marrie, C.E.O. Campbell River/Nootka Community Health Council

Alan Maynard, York Health Policy Group, University of York, UK

John Maynard, North Shore Health Region

P. McDonnel, Simon Fraser Health Region

Anne McFarlane, Deputy Minister CEO Focus Group

Dr. G. McFetridge

R.G. Moody, M.B., B.S., The Medical Clinic, Fort St. John

Dr. Michael Moran, Northern Medical Society

Gary Moser, HEABC

Mark Mountain

Peter Newbury, M.Div., M.D., C.C.F.P., F.C.F.P., Director United Church Health Services

Dora Nicinski, Deputy Minister CEO Focus Group

Patrick O'Rourke, Ministry of Health

Ron Paull, Quesnel Citizens for Health Care

G. Peary, Valley Health Region

Elaine Peaston, College of Physicians and Surgeons of BC

Dr. Howard Platt, Ministry of Health

Dr. Michael Rachlis, M.D., M.Sc., F.R.C.P.C.

Raymond Raj, Kitimat and Area Health Council

Marie Ramsay

Murray Ramsden, C.E.O., Okangan Similkameen Health Region

Scott Ransome, Manitoba Health

David Reynolds

David Richardson, C.E.O., Northern Interior Regional Health Board

C. Riley, C.E.O., Greater Trail Community Health Council

Elizabeth Riley, Council of University of Teaching Hospitals

G. Roberge, Vancouver Island Health Region

R. Roger, Capital Health Region

Don Rosenbloom, Society of Specialists

Brian Schmidt, BC Cancer Agency

David Schneider, Centre for Health Services and Policy Research

Dr. M. Schoenfeld, BCMA

Andrew Sear, M.B., B.S., D.A., D. Obst., Fairview Medical Associates

G.S. Singh, F.R.C.S. (Canada) Diplomate American Board of Neurological Surgery

Dr.Michael Smialowski, M.D., Dipl. Sport Med.

Dr. Fen Smit, Campbell River Doctors

G. Spitz, North Shore Health Region

Kelly Squire, Yukon Department of Health and Social Services

Dr. J Stephen

E. Strand, Vancouver Island Health Region

Simon Sutcliffe, Deputy Minister CEO Focus Group

Dr. S. Sutton, Northern Medical Society

Dr. Tim Temple, M.B., B.S., C.C.F.P.

Inez Thederahn

Yves Theriault, Quebec Ministere de la Sante et des Services Sociaux

Darrell Thomson, BCMA

Aubrey Tingle, M.D., Ph.D., F.R.C.P. (C), BC Research Institute for Children's & Women's Health

Rick Trimp, Northwest Territories Department of Health and Social Services

Dr. John Turner

Monika Turner, Ontario Ministry of Health and Long Term Care

Dr. Rob Underell, FVHR Corporate Office

Dr. Morris VanAndel, College of Physicians and Surgeons of BC

R. Walker, C.E.O., Cranbrook Health Council

Annette Wall, Ministry of Health

Sherry Webster

C. Wise, Cariboo and Chilcotin District Health Council

M. Wolfram, Thompson Health Region

Dr. Robert Woollard, UBC Department of Family Practice

Dr. Kay Wooton, Deputy Minister CEO Focus Group

Mike Wright, Fort St. John Medical Staff

Dr. Yu, Society of Specialists

P. Zanon, South Fraser Health Region

Nova Scotia Department of Finance

Annual Accountability Report for the year 2000/01

December, 2001

NOVA SCOTIA
Department of Finance

102-03470/

Department of Finance

Annual Accountability Report for the Fiscal Year 2000/01

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Accountability Statement

The accountability report of the Department of Finance for the year ended March 31, 2001, is prepared pursuant to the Financial Measures Act (2000). The Act requires the reporting of outcomes against Department of Finance business plan information for the fiscal year. The reporting of Department of Finance outcomes necessarily includes estimates, judgments and opinions by Department of Finance management.

We acknowledge that this accountability report is the responsibility of Department of Finance management. The report represents, to the extent possible, a complete and accurate representation of outcomes relative to the goals and priorities set out in the Department of Finance business plan for the year.

original signed by
Honourable Neil J. LeBlanc
Minister of Finance

original signed by
William D. Hogg
Deputy Minister

Message from the Minister

The Department of Finance is pleased to produce its first Accountability Report under the provisions of the Financial Measures Act of 2000.

The outcomes expressed in this report are based on the priorities and goals set forth in the Department's business plan for 2000-2001.

The most significant impact from Government restructuring on our department, resulted in the transfer of Procurement, from the Department of Finance to the Department of Transportation and Public Works.

In the 2000-2001 fiscal year, the Government, through the Department of Finance, fulfilled its commitment to present open and transparent financial accounting to the people of Nova Scotia. Our full compliance with Generally Acceptable Accounting Principles (GAAP) ensures credibility and accountability. During this time, a comprehensive Tax Credit Review of tax incentive programs resulted in improvements, and in addition, the new Tax on Income system for Personal Income Taxation was implemented.

Most importantly, all our activities were successfully directed towards controlling government spending and reducing the deficit. This was accomplished while providing professional and quality service to the taxpayer. All aspects of the Department's core functions are aimed at achieving fiscal stability and building better government.

Honourable Neil LeBlanc
Minister of Finance

Impact of Government Restructuring

Restructuring activities for the Department of Finance include the following:

- Procurement was transferred to Transportation and Public Works
- Pensions Regulations was transferred to Environment & Labour
- Corporate expenditure control/ monitoring was transferred to Treasury and Policy Board
- Internal audit function for all of government was centralized within the Department of Finance
- Selected staff reductions throughout the Department

As of March 31, 2001, staff in the Department totalled 219.7 (annualized person years), which is a net reduction of 5.7 from the previous year due to the transfer out of functions to other departments and the transfer in of staff due to the centralization of the corporate internal audit function. Many of the above restructuring activities, initiated in 2000-01, will be fully implemented in 2001-02.

Department Accomplishments

The Department of Finance mission statement is "to establish a fiscal climate conducive for economic growth and to provide central agency support and policy direction for effective management of the Province's finances, government procurement, and pensions administration." The Department has established six goals to support this mission statement:

- To enhance financial accountability in the management and control of the Province's finances.
- To enhance Nova Scotia's long-term fiscal position, provide for fair and efficient taxation and promote economic growth in a strategic way that balances the social responsibilities of government, debt reduction, and a lowering of the tax burden.
- To provide a core set of high quality corporate services and infrastructure that supports the efficient and effective management of the Province's public resources, including: government accounting, payroll, pensions, budgeting, treasury, procurement, statistics, and internal audit.
- To achieve effective money management that maximizes return on investments and minimizes debt servicing costs, within acceptable risk tolerances.
- To ensure a responsible regulatory environment that safeguards pension entitlements and ensures fair and competitive procurement.
- To foster an environment that values its clients and its employees.

The Department's goals directly support the Government's priorities as reflected in the Throne Speech and Government's stated commitments. Many activities within each of the core business functions of the Department reinforce these linkages. Economic development is enhanced with the overall fiscal health of the Province and through effective taxation and procurement policies. Building a healthier province and developing our human potential is supported by taxation policy and programs that favour low income households as well as balancing the needs of social program funding with other fiscal requirements. Participation in reviewing programs directly supports the Government's directions as does the development of accountability mechanisms of legislation and regulations. As an integral part of the Department's culture, Finance is a dynamic organization that reviews its services on an ongoing basis and responds to client needs and feedback within its fiscal capacity. All aspects of the Department's core functions are aimed at achieving fiscal stability and building better government.

In order to help achieve its goals, the Department set a number of priorities for 2000-01. The following is a listing of those priorities and an overview of the department's accomplishment for each one.

Achieving Financial Accountability

- Enhance accountability and governance structures as they relate to public policy and administration of financial resources through the continued improvement of the Province's financial management policies and procedures.

  Accomplishments:

  - Introduced Government Accountability legislation in the *Financial Measures (2000) Act* that would require the government to submit four year consolidated fiscal plans and a balanced budget starting in fiscal year 2002-03.
  - Require government service organizations and government business enterprises to submit business plans to the Minister.
  - Enacted legislation that prohibits government service organizations and government business enterprises, including regional school boards and district hospital authorities, from incurring a deficit.

- Improve overall fiscal management by producing more relevant and timely financial reports and by implementing recommendations of the Auditor-General in a timely manner.

  Accomplishments:

  - Published four year end quarterly reports in 2000-01 as required by legislation within 90 days of the end of the quarter.
  - Released 1999-2000 audited Public Accounts on December 18, 2000. These financial statements continued building on the Province's transition to fuller compliance with generally accepted accounting principles, e.g. reporting of Tangible Capital Assets and consolidation of school and health boards.

- Strengthened monthly forecasting requirements by departments to ensure that variances to budget are identified in time to address the related issues.
- Reviewed in detail the 1999 Auditor General's Report dealing with Liability and Risk Management Function, and implemented many of its recommendations.

- Continue to develop reporting and control instruments to ensure full transparency and accountability in the procurement process.
  - This responsibility has been transferred to the Department of Transportation and Public Works.

Enhancing the Province's Fiscal Interests

- Effectively represent Nova Scotia's interests in federal-provincial negotiations and discussions respecting such issues as national trade deliberations, transfer programs, tax collection agreements, and the statistical databases which support them.

  Accomplishments:

  - Researched, analysed and represented the province's interests at numerous Federal/Provincial/Territorial as well as Provincial/Territorial meetings throughout the year respecting such key issues as:
    - the existing Fiscal Imbalance within Canada between the Federal government and the provinces and the urgent need for additional health care funding to finance essential programs and services.
    - renewal of the Fiscal Arrangements Act between the Federal government and the provinces respecting the equalization transfer program for 2004-05.
    - continued work on the development of a new Tax Collection Agreement between the province and the Government of Canada

- Continue to enhance the province's ability to provide for accurate and timely economic and fiscal forecasts to facilitate effective business planning by government.

  Accomplishments:

  - Developed a new economic forecasting model for the province as well as enhancements to the province's capabilities for econometric impact analysis.
  - Continued enhancements to the province's revenue forecasting models to more accurately reflect updated fiscal and economic trends and changes in the system of provincial income taxation.

- Provide analysis and advice on emerging and ongoing taxation issues such as working to enhance the Province's control over its tax systems, effectively representing Nova Scotia at federal-provincial tax policy discussions, implementing the Tax on Income System, and continuing with the Tax Credit Review process.

  Accomplishments:

  - Implemented the new Tax on Income system for Personal Income Taxation within the province (TONI).
  - Completed Phase II of the comprehensive Tax Credit Review of the province's existing tax incentive programs and implemented changes designed to improve their effectiveness within the Nova Scotia economy.
- Develop a strategy for the long-term reduction of debt in the Province.

  Accomplishments:

  - Produced a four year fiscal plan that eliminates the structural deficit starting in 2002/03 as a fundamental first step.
  - Improved financial statements to provide a comprehensive picture of the province's fiscal position through consolidation of financial obligations by all entities accountable to government.
- Develop a strategy that will reduce the Province's exposure to financial risk on such items as capital market exposures in foreign exchange and unforeseen events.

  Accomplishments:

  - Adopted conservative policy parameters (not to exceed 20% of the portfolio).
  - Reduced foreign market exposure to 30.8% as of March 31, 2001 from a high of 72% in 1992. Target of 20% or below will be met by Fiscal Year 2004-05.
- Develop and implement a strategy to optimize exposure arising from off-balance sheet transactions (guarantees, leases, etc.).

  Accomplishments:

  - Developed a tracking and review process to optimise this exposure within Department of Finance. The extent to which individual agencies, boards and commissions (ABCs) are permitted to assume off balance sheet risk exposures has the potential to limit the effectiveness of the strategy.
- Maintain or enhance funding positions of the Teachers' Pension Plan and Public Service Superannuation Plan.

  Accomplishments:

  - Benchmarked and outperformed financial markets by about 4.3%. Because of this better than average performance, the funding positions of the two plans decreased only slightly, despite a year in which the markets experienced significant downturns. The teachers'

Pension Plan went from a funded position of 95.4% to 94.7% and the Public Service Superannuation Plan went from 103.4% to 98.1%.

- Develop a set of objective criteria for Cabinet to assess loans and guarantees related to business development programs.

  Accomplishments:

  - Developed the criteria which has been approved by Cabinet for staff assessment and recommendations related to loans and guarantees for business development programs.

Providing Corporate Services

- Review and revise procurement processes, documentation, and support systems to maximize organizational effectiveness, efficiency, and service quality to meet quality assurance and service standards.
  - This responsibility has been transferred to the Department of Transportation and Public Works.
- Where appropriate, extend procurement and CFMS service offerings to include the MASH sector.

  Accomplishments:

  - Extended an offer to the MASH sector that will allow them to access SAP licences free of charge. This allows for the development of a set of core competencies and standardization of resources across the broader public sector. The MASH sector can take advantage of the province's procurement services through the Internet or direct contact. Extending the province's procurement services to the broader public sector allows the MASH sector to benefit from bulk purchases, standing offers, tendering expertise and leasing agreements.
  - Procurement activities have been transferred to the Department of Transportation and Public Works.
- Review business practices and plans regarding the distribution of government and public sector tenders to sustain a fair and open procurement process with emphasis on e-commerce.
  - This responsibility has been transferred to the Department of Transportation and Public Works.
- Implement recommendations related to restructuring government warehousing and logistics operations.
  - This responsibility has been transferred to the Department of Transportation and Public Works.

- Create advisory task forces related to government procurement policies and practices for both the private sector and MASH sector.
  - Procurement has been transferred to the Department of Transportation and Public Works.

- Provide guidance and support to departments and agencies on significant accounting, procurement, and financial issues.

  Accomplishments:
  - Reviewed and updated government-wide accounting policies and procedures to be implemented in the 2001-02 fiscal year.
  - Procurement has been transferred to the Department of Transportation and Public Works.
- Co-ordinate improvements in service delivery in payroll and benefits administration.

  Accomplishments:
  - Reviewed the payroll administration function and alternative service delivery options. Continued internal operation with reduced staff was found to be the most cost-effective way of delivering this service.
- Improve the co-ordination of the Internal Audit functions across the provincial government.

  Accomplishments:
  - Centralized the Internal Audit function within the Department of Finance. Audit activities are being co-ordinated by a Deputy Minister Steering Committee.
- Improve the efficiency and effectiveness of the delivery of pension services to plan members and beneficiaries.

  Accomplishments:
  - Initiated upgrading of the computerized pension administration system.
  - Improved communications with members through enhanced web services.
  - Reduced public service refunds backlog by 50%.

Effective Money Management

- Develop and implement a public capital risk allocation methodology.

  Accomplishments:
  - Continue to review options and issues related to developing such a methodology.
- Integrate treasury management systems and capital market information systems to enhance the overall control, monitoring, and performance of the Liability Management and Investment Divisions.

  Accomplishments:
  - Developed procedures to assess and monitor credit risk of investment partners to ensure that risk exposure is within acceptable limits.

- Formed an Operations Sub-committee to handle settlement and operations issues as well as review and improve procedures.

- Upgrade Capital Markets Financial Information systems to enhance investment and risk management decision making.

  Accomplishments:

  - Enhanced bond management capabilities used for both asset and liability management by implementation of the BOND EDGE system.

- Develop and implement an effective risk review process in respect of risk assets booked directly by the Province or through Crown agencies and corporations.

  Accomplishments:

  - Initiated research and review of issues related to this priority. Obtained information from other jurisdictions that have experience in this area.

Ensuring Responsible Regulatory Environment

- Effect amendments to the *Pensions Benefits Act* to achieve the goals of harmonization with other jurisdictions, clarification of provisions and other measures addressing the needs of plan members and sponsors.
  - This responsibility has been transferred to Environment & Labour.

Developing a Quality Organization

- Contribute to the quality and professionalism of human resource management in the department.

  Accomplishments:

  - Provided effective quality human resource advice and assistance to management in dealing with human resource management issues within the department.

- Continue to develop a productive and skilled workforce in a healthy and safe work environment.

  Accomplishments:

  - Assisted management in determining appropriate qualifications and recruitment strategies when filling vacant positions.
  - Provided assistance to management and employees in securing appropriate training and development information for the purpose of employee development and skill maintenance.

- Acquire and develop technologies to improve productivity and output quality.

  Accomplishments:

  Implemented a variety of system upgrades designed to support accessability, speed, availability, and performance of IT systems. This included installation of new desktop operating systems (Windows 2000); provision of wireless network connectivity

(increased availability/access to the Provincial network for clients); implementation of a technology refresh of network components and PC's; and provision of access to Network Fax services.

- Continue to improve staff training opportunities to provide the skills necessary to achieve the Department's strategic goals.

  Accomplishments:

  - Ensured that up-to-date information on training and development opportunities were made available to staff.
  - Provided feedback on training initiatives and staff training needs to the Staff Training and Development Division of the Public Service Commission to assist them in delivering the types and level of training required.

Human Resources

During 2000-2001 the following key initiatives were undertaken to support the Department of Finance:

- Improve the service in human resource program delivery.

  Accomplishments:

  - Ensured appropriate staffing levels required by client base.
  - Provided continuous learning opportunities to HR staff.
  - Encouraged management and employee feedback for areas of improvement
- Deliver training and provide consultative support to managers in performance management and succession management.

  Accomplishments:

  - Provided management and employees with training and coaching on an as needed basis in the area of performance management. Thus far no formal program has been launched for succession management.
- Establish goals/plans for management of short term illness and LTD in support of the implementation of corporate disability management policy.

  Accomplishments:

  - Worked with senior staff on management of short term illness and related issues. Worked closely with case management staff of Maritime Life (LTD) in assisting employees returning to work from LTD.
- Assist with organizational review and restructuring as required.

  Accomplishments:

  - Participated in organizational review and restructuring activities in the Department.

Information Technology

During 2000-01 the following key initiatives were undertaken to support the Department of Finance:

- Work closely with the department to deliver an IT Strategy to address the IT-related objectives within the Business Plan.

  Accomplishments:

  - Worked with senior management in the department to ensure prioritization and alignment of IT projects with departmental business plans.
- Enhance the department's operational abilities through the delivery of value-added information systems and services.

  Accomplishments:

  - Provided support for the following business applications/initiatives:

    Salary Analysis System

    Documentation of Financial Statements Preparation process.

    Enhancements to the PCDOCs-based Correspondence Management system.

    Resource Management system.

    Pension Benefits.
- Continue to support and safeguard the department's existing production information systems and technologies.

  Accomplishments:

  - Performed regular upgrades to network and desktop software to ensure compatibility, stability, reliability, and desktop and network security.
- Manage the province's CFMS environment.

  Accomplishments:

  - Worked with the CFMS Administrator to assist in the move to the EDS Data Centre while maintaining connection to the provincial government network.

Financial Services

During 2000-2001 the following key initiatives were undertaken to support the Department of Finance:

- Meet the department's needs with respect to financial analysis in business case development, user fee recoveries, cost/benefit analysis, business planning, estimate and forecast planning and other projects.

  Accomplishments:

  - Contributed to the Department's business planning which included participation in development of the business plan and financial analysis related to government restructuring and meeting targets.
  - Analysed departmental expenses and recoveries, on a monthly basis, and prepared a Monthly Forecast Report for Senior Management.

- Continue to streamline/ensure efficiency of financial procedures and processes within the Department of Finance in compliance with PSAB government accounting guidelines.
  Accomplishments:
  - Provided accurate financial information on a timely basis, as per audit requirements, to Government Accounting Division which assisted in their preparation of consolidated financial statements.
- Support government's agenda with respect to implementation of major revisions to financial management accounting policies.
  Accomplishments:
  - Implemented and ensured adherence to changes in limits for operational spending, the new Travel and Moving and Relocation policy, and a new tax ruling issued by The Canada Customs and Revenue Agency (CCRA).
- Continue utilization of the Asset Management Module of the Corporate Financial Management System (CFMS/SAP) in accordance with the corporate Tangible Capital Assets Policy. Ensure appropriate and accurate recording of capital assets resulting in information which will increase efficiency in the management of capital assets.
  Accomplishments:
  - Ensured the accurate recording of the purchase of computer hardware and software in accordance with the Tangible Capital Assets (TCA) Policy.
- Continue development and implementation of appropriate procurement procedures and processes for the Department of Finance. Continue information sessions/training for departmental and accounting staff to ensure appropriate knowledge and accountability with respect to corporate procurement policy.
  Accomplishments:
  - Implemented and ensured adherence to the revised Procurement Policy and introduction of the fleet/fuel card program introduced by the Procurement Branch.

Financial Results

Core Business Function	Budget Allocation (thousands) 2000-01 Estimate	Budget Allocation (thousands) 2000-01 Actual	Explanation of Variance
Senior Management Minister and Deputy office, Legal Services, Communications, Fiscal Strategy including the functions of Assistant Deputy Minister, Planning & Budgeting, and Policy Co-ordination	1,456	1,247	Staff vacancy savings and unexpected recoveries
Controller Controller's Office including Government Accounting, Payroll, Internal Audit and Corporate Financial Management System (CFMS)	2,729	2,880	Increased software maintenance costs for SAP licences
Investments, Pensions & Treasury Services Exec. Director, Investment Management, Treasury Services, Pensions Services and Regulation, Liability Management and Cash Management	830	767	Staff vacancy savings
Policy Development Exec. Director, Fiscal Policy, Economic Policy & Analysis, and Statistics	1,609	1,520	Staff vacancy savings and general operating efficiencies.
Procurement Services Exec. Director, Purchasing, Public Tender's Office, Supply Services and Technology Services	1,317	1,480	Increased costs as result of delays in implementing the reorganization.
Corporate Services CSU functions of Human Resources, Information Technology and Financial Services	2,804	2,431	Staff vacancy savings and general operating efficiencies.
Prior Years' Recoveries	(1,447)	(1,621)	Recoveries higher than budgeted.
Net Program Expenses Tangible Capital Assets Adjustment Net Program Expenditures	9,298 (412) 8,886	8,704 (412) 8,292	See note below

Note: Savings were realized in vacancies throughout the department, general operations and Prior Years' Recoveries, offset by an increase for SAP licenses and the delay in implementing the Procurement Division re-organization. Overall, the Department of Finance net program expenditures in 2000-01 were $594,000 less than budgeted and $234,000 less than in 1999-2000.

NOVA SCOTIA DEPARTMENT OF FINANCE